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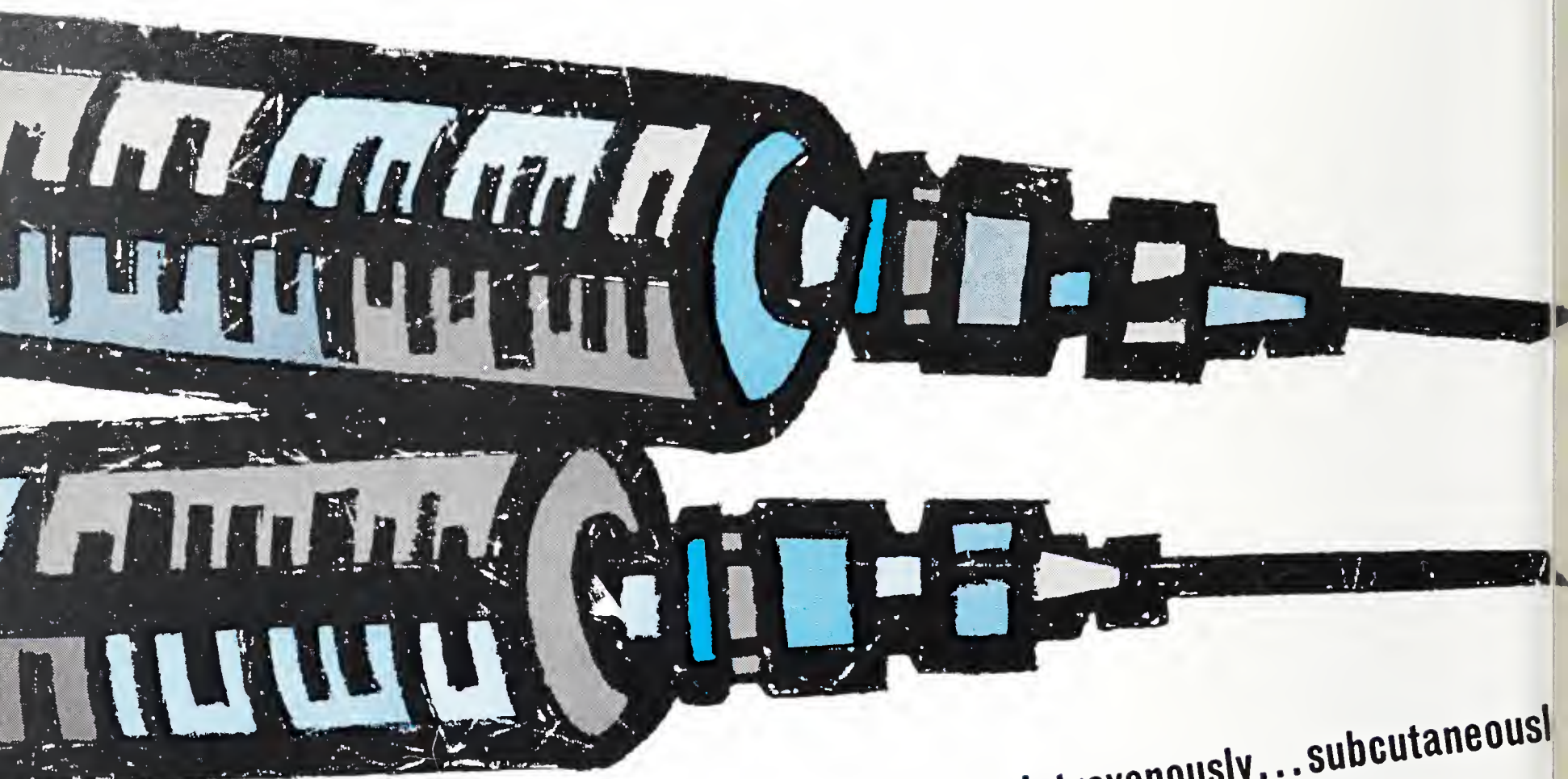
PSYCHIATRY



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References: (1) Ross, S.; Puig, J. R., & Zaremba, E. A.: **Antibiotics Annual 5**:803, 1958. (2) McCrumb, F. R., Jr.; Snyder, M. J., & Hicken, W. J.: **ibid.**, p. 837. (3) Payne, H. M., & Hackney, R. L., Jr.: **ibid.**, p. 821.

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Index

Volume XLI
Number 3
January 1964

EDITORIAL 97

Psychiatry

ARTICLES

PSYCHOANALYSIS, PART I: Freud ..... *Donald Woodside* 6T5

PSYCHOANALYSIS, PART II: The Post-Freudians ..... *Same Izenberg* 6T5

PSYCHIATRY and RELIGION ..... *G. S. Duckwork* 6T5

PSYCHIATRIC EMERGENCIES ..... *Richard M. Gladstone* 6T4

PSYCHIATRY IN THE USSR ..... *Bernard Raxlen* 6T5

FEATURES

RECENT ADVANCES 119

MEDICAL HORIZONS 129

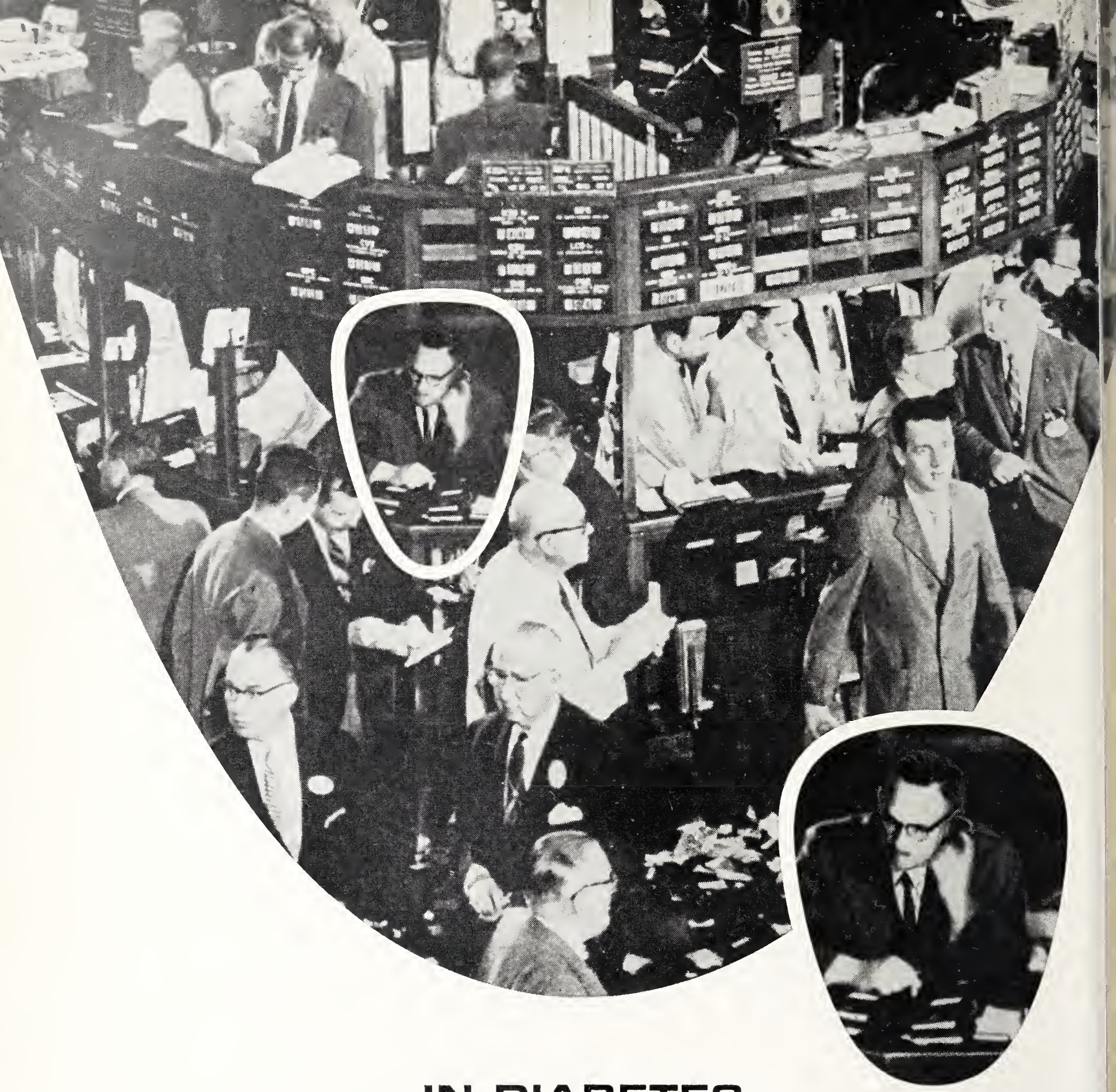
ABSTRACTS 120, 130, 137, 138

LANDMARKS 138

BOOK REVIEW 105

INDEX TO ADVERTISERS

PARKE DAVIS ..... Inside Front Cover, 91
JOHN WYETH 92
FRANK W. HORNER 94
COW & GATE 96
POULENC 98
SMITH, KLINE & FRENCH 106
HOMEWOOD 112
U. OF T. BOOKSTORE 118
OSBORNE'S PHARMACY 130
ABBOTT ..... Inside Back Cover
FROSST ..... Outside Back Cover



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Editorial

The subject of this issue of the Medical Journal is Psychiatry. There can be no question as to the worthiness of this discipline being included as a suitable topic for discussion because of the great and universal relevance of psychiatry to all other areas of medicine. Some illnesses are entirely psychological in origin, while all illnesses are at least partly psychological in their substantive make-up. It is common knowledge that the great bulk of general office practice is comprised of patients showing either no organic findings, or findings incompatible with the nature of their complaint. This much is basic; this much is prologue.

It is prologue because this issue is somewhat different from previous issues of the Journal devoted to this same field. This Journal is dedicated more to the nether aspects of the subject, to the horizons rather than to the foreground of conventional psychiatry. Three of the five articles printed here are directly concerned with psychoanalysis, a branch of psychiatry much discussed but little understood. It has been the experience of this writer that the mere mention of the word "psychoanalysis" produces in certain circles a reaction somewhere between patronage and disgust. In this neatly-ordered, mechanistic medical world of ours there seems to be little toleration for phenomena supposedly outside the realm of physico-chemical law. Thus, it is commonly assumed that all mental illness will eventually be explained in terms of upset bodily chemistry or genetics, and will, in time, be successfully treated on this basis. For certain mental illnesses, perhaps some of the commonest and most significant, such as schizophrenia, I believe this is true. But on the basis of much research, including certain classical experiments in which neuroses and psychoses were induced in previously "sane" animals, I am equally certain that much of mental illness is environmentally induced, and amenable, therefore, to what I believe will be a lasting school of, if not purely psychoanalytical, at least dynamically oriented therapeutic technique. For this reason the articles on psychoanalysis have been included.

The first two articles may be considered as basic orientation in the history and some of the theories of psychoanalysis. Naturally in the brief space allotted, the authors can do little more than hint at the complexity of their subjects. The third article, connecting psychoanalysis with religion, is not an exercise for the unwary but has been included as an example of the type of problem in which the advanced psychology of contemporary analysis finds itself immersed. It is an interesting article, and a biassed article, in the best sense of the word. It is hoped that this series of articles will provoke some thoughtful consideration of the subject.

The issue closes with two articles that are more conventional in scope. One considers the practice and position of psychiatry in the Soviet Union, presenting the little-known and somewhat unusual background of Russian psychiatric thought. The basis of Soviet psychiatry, as will be seen, is much different than our own, and the author comes to some interesting conclusions regarding the efficacy and type of treatment available in the U.S.S.R. The final article is an excellent and not otherwise easily obtainable compendium of the classification and treatment of psychiatric emergencies.

This is a different issue, certainly. We think it is an interesting one. *S.P.B.*

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Psychoanalysis, Part I: Freud

by *Donald W. Woodside*

Sigmund Freud's lifetime (1856-1939) spanned the advance of Medicine from mediaeval methods, through the spread of antisepsis and anaesthesia, to the use of modern chemical warfare against the micro-organisms which threaten us. But he did not partake in this exciting revolution. He gave up his work in Neurology about 1890 to study the equally perplexing but more elusive disorders of the mind. He stepped into the psychological study of Hysteria, but early decided to forsake hypnotism, the standard tool, for the technique of free association. The startling discoveries he made about the nature of the mind and its unexpected contents brought down on his head the scorn of his profession. But his observations and the theories he devised to explain them are of vast importance to all who are curious about the strange and terrible malfunctions of the psyche.

Not only have they provided a rare and valuable tool in the understanding and treatment of mental illness but they have been woven into modern man's view of himself and his society. Freud's insistence that all our behavior could be understood as a part of cause and effect relationship has won him high respect in our rational era, and stimulated many followers to pursue the paths he opened up in the mental jungle.

What, then, are the elements which make this a work of genius? First of all, he demonstrated convincingly that every man has an unconscious, a part of his mind about which he knows nothing directly. He showed that there is an important dynamic relationship between the conscious and unconscious mental processes. He traced the normal pattern of development of infantile sexual interests through those early years we have all more or less totally forgotten. Finally he showed how the maladjustments in this process could cause later disturbances in the psyche. Freud was first and foremost an empirical scientist. But his theories carry the seeds of their own destruction. He proved most rationally that reason is suspect. He was never willing to admit that between evidence and theory lies an important variable, the point of view of the scientist.

Let us return to the unconscious. Its contents offend reason and sensibility. Reality is ignored completely. Analysis of a dream (which is a modified expression of the unconscious — see U of T Medical J. Feb. '63) will show that time relationships are distorted, long repressed memories being fused with events of yesterday. Space is altered, with components of one place mixed confusingly with those of another. Diametrically opposed meanings exist side by side. For example, a young man may satisfy both a desire for freedom and one for authority by joining the army. Basically its content is a collection of repressed infantile experiences and desires.

In this shadow world the sexual instincts are the motive force. Freud did not believe in a mysterious source of psychic energy. He thought it was produced by tension on certain physical structures of the body demanding release. Release produces pleasure and gratification. The organs through which pleasure is gained are the mouth, anus, genitals or phallus — the erotogenous zones of the body. The energy arising, called the *libido,* serves the sexual instincts, called the *id*. They act to gain pleasure in an uncompromising way and thus are said to operate on the *"pleasure-principle"*.

The loyal opposition delegated to modify the sexual instincts in the interest of survival and social harmony are the ego-instincts. These are said to operate on the *reality-principle*. All our behavior is thus a compromise between these forces.

At this point mention should be made of Freud's later formulation of the instincts, in which the desire for pleasure and self-preservation were united as *eros*, the force of life, and pitted against *thanatos,* the death instinct, which Freud perceived as a tendency in all nature. The healthy outward diversion of this energy of self-destruction becomes aggression, at first. Normally fusion occurs between Eros and Thanatos, with the energy of aggression diverted into constructive and creative endeavours. If not, the aggression remains destructive, either to oneself or to others. However, Freud could never find an acceptable source for this death impulse. It has remained an interesting theory, and is not much used in therapy.

Structure of the Psyche

The structure of the psyche is divided in two ways; first into conscious, preconscious (that which may be recalled at will) and unconscious. These are the layers of accessibility of the mind. Secondly, the psyche is divided into its component instincts, *id, ego,* and *superego*. The id we have described: it is unconscious. The ego is a precipitate of learning and experience in the world. It is the form of con-

sciousness produced as a result of interplay between the id, superego, and reality. It has a foothold in the unconscious, as it has at its disposal the mechanism of repression, which can bar the door of consciousness to the id without one's awareness. The ego is a somewhat obscure concept because Freud dealt with it only as an organizational and defensive entity. The superego exists in both the conscious and unconscious spheres. Its energy arises from the id impulses which it must control. It is acquired late in the genetic process (which is what I shall call the development of the sexual instincts in the growing child), as a set of rules internalized to solve the Oedipus Complex.

The Genetic Process

The genetic process is the Freudian term to identify the process by which the infant acquires a personality. Freud believed that the origin of the individual psyche could be traced back to the interaction of the biologically determined and universal id with the external world, during the first six years or so of life. Variations in adult personality and the way in which the individual handles problems become comprehensible in the light of early experience.

Stages

The child passes through a fairly regular series of orientations during each of which the psychic energy derived from the pursuit of pleasure, the libido, is focussed on a specific erogenous zone. At each stage the personality gains considerable organization around a form of life dominated by powerful urges and great pleasures.

The many stages are often seen as overlapping in the child, or merged later in the adult's unconscious. No stage is ever completely given up. To the same degree to which the problems of any stage remain unsolved and its urges frustrated, to that degree these problems are repressed into the unconscious and remain unchanged, with a magnetic attraction for the energy of the psyche. The problem of later stages cannot then be met adequately. If at a future date the ego meets difficulties, it may seek to retreat to a stage at which the libido is more firmly fixed.

Primary Narcissism

The baby is thought to have little basis for distinguishing himself from the external world. All things whose importance he can grasp — the bedclothes, diapers, mother's breast or bottle are a part of his bodily comfort and thus of himself. Moreover, as if by magic, he can control any disagreeable changes in his world, like wetness or hunger, by simply crying. For him reality poses no problems, for his relationship to it is so far beyond his control that he must feel either omnipotence or complete frustration. He has no resources to turn to, so obviously there are no resources. As the child experiences frustration and delay in gratification he begins to see the mother as different from himself. One of the major dynamic forces becomes his fear of loss of his mother's love and attention.

Oral

To say that the oral stage gives the infant sexual pleasure may seem to be misusing the word "sexual", which is well defined in common usage. But Freud defends his nomenclature on the grounds that investigations of neurotics and normals shows that the same libido which invests the genital urges of adolescents originates in the infant's drive for pleasure, and the prototypes of later conflicts of a more obviously sexual nature are to be seen in the infant's id and ego. The oral stage is the stage of dependency on the mouth for food and pleasure. That the child sucks for food is obvious. That he sucks for pleasure has been observed by every parent, when he sees the squalling baby turn delightedly to the "pacifier". The strength of the thumbsucking habit is further proof.

The importance of this stage in developing awareness of objects other than the mother may be seen as well. He tries to swallow everything, to incorporate it in himself, but gradually realises that there are "things" and "me". A product of this stage is the recognizable tendency of adults to internalize outside influences as though they were their own, and to externalize their feelings and see them as coming from the people around them. The child may become too dependent on oral gratification if weaning is too long delayed. Thus a dependent adult is produced or one with such oral needs as alcohol, chewing gum, or tobacco. He may become pessimistic or demandingly aggressive in later life, if overly frustrated in his infant oral stage.

Anal

Observation of children, as well as analysis of adults, shows unexpectedly strong emotional attachments to the excretory function. The child enjoys defecating, yet conversely enjoys the mastery over himself implied in retaining his feces. As well, the child is making an attempt to control his bowel movements through his imperfectly developed nervous system to please his mother. He is doomed to fail occasionally and suffer loss of love. Finally the child's interest in defecating is opposed by the mother who demands regularity.

This whole area of conflict becomes a battlefield of great importance. The child must relinquish his omnipotence. If he can accept the mother's desires as his own, and try to work constructively towards the desired toilet training, he will gain a valuable sense of achievement and identification with his parents. If he is forced to succumb to reality, his inner controls will take form in lasting antagonism to external authority. This will result, in later life, in such character disorders as defiance of authority or anxious compliance.

During the anal stage, there is a further development in object relations. In the oral stage the infant saw that the mother's breast or the bottle had a life of its own, different from his. By the anal stage he has gained considerably more respect for reality. But his feces he treats as something special, as little presents he has given the world. They are a part of him. He delights in them. But he must learn to regard them as foreign. A disturbance in the manner in which the anal conflicts are solved can produce the typical adult "anal" character, which regards people as possessions, and possessions as having abnormally great significance for him. His possessions are not well differentiated from himself. He feels threatened by many of the disruptions in the external world which a normal person would view coolly, from a distance.

Phallic

During the fourth year it has been observed that the libido shifts its focus to the genital zone. Infantile masturbation and sex play with other children are virtually universal. The id derives its pleasures from the stimulation of the genitals and is opposed by parental authority and a powerful fear, the castration complex.

The child becomes frankly curious about sexual matters, both among friends and with parents. He cannot avoid being rebuffed, either directly or indirectly, in his search for knowledge. Nor can he avoid seeing that his father has certain privileges concerning his mother which he lacks. She is the focus of the child's life, yet there is someone who seems to be more important to her.

The Freudian view is that the conflict with the father is over a literally sexual possession of the mother. The child, by this time, has ascribed to mother and father the omnipotence which he originally found in himself, and with good reason. Physically, mentally, socially, and in every way visible to a four-year-old boy, his father is a real, live giant. He feels murderous hatred for his father. He wishes him gone, dead, away, for the giant is taking precedence with his woman. By the mechanism of projection the boy sees that his father feels the same way towards him. Such an adversary terrifies the child. Also, the boy has grown to love his father, and the ambivalence produces conflict. The boy fears loss of love from the father as well as from the mother. Finally, his mother must sooner or later reject his advances, either directly, or more subtly. He can't help feeling the powerful social opposition to incest.

The penis at this stage suddenly becomes very important as a source and potentially as a means of gaining pleasure. He notices that little girls, whom he had previously accepted as brothers, are different. They have no penis. He is inspired by fear that he, too, could lose his. Warnings to stop masturbating associate this threat with sexual pleasure. It may happen that someone will threaten to cut it off. This fear of castration becomes a powerful stimulus to cease in his forbidden rivalry with his father.

This conflict of the boy with his father produces the Oedipus Complex in the child. It is named after the Greek myth in which Oedipus was fated to marry his mother and murder his father, and unwittingly does so. Freud would say that we are all fated to do the same, in fantasy.

The disruption of the Oedipus Complex is solved by a further step in the genetic process. The child identifies with the father; unconsciously he becomes the father, as the easiest way to enjoy the mother and end the enormous anxiety of his conflict. He introjects, takes into his own mind, a well-organized complex of attitudes, typically those attributed to the father by the child. Thus the crisis is solved.

If not resolved in this way, the conflict becomes very important in the dynamics of the adult personality.

The Superego

The parental attitudes and prohibitions which the child introjects have the power of supreme authority, because the parent is regarded as omnipotent. The parent becomes the conscience. If the child has formed a warm relationship with the parents by a healthy solution of previous stages there will be an important mellowing influence on the repression experienced by the child and introjected as the superego. It must be remembered that the superego operates with the energy of the id impulses which it suppresses. It retains this power and much of its crude pattern of reaction throughout life.

Phallic Stage of the Girl

Up to this point the genetic process is identical for girls and boys. At about four years of age the girl realises that she has no penis. She develops penis envy. Thus her castration complex drives her into the Oedipus Complex. She identifies the penis with a child, and longs to have a child by her father to restore the penis she has lost. She loves her father intensely and longs for him in a directly sexual way. She hates her mother as a rival. Most of the same forces which forced the boy to identify with his father act on his sister now. She identifies with mother, introjecting the parental image. However the prime motivating factor of the castration complex operates to initiate not to end the Complex. There is no neat solution; the Complex remains operative indefinitely. The female superego never attains the power and independence of the male one, making women seem more pliable and less concerned with abstract principles.

At about the age of six Freud believed that the major instinctual problems had been resolved, producing an organization of the psyche which would be basic for that person throughout life.

Latency

Solution of the Oedipus Complex, allied with lessening of the biological sexual urge, introduces the latency period. The libido becomes de-sexualized until puberty. Freud had little to say about this vital period, as it did not contribute specifically to the development of the sexual impulses. However, this period of socialisation and enormous intellectual and motor development in the child is given considerable importance in the treatment by a Freudian psychoanalyst. Freud was battling hard for acceptance of his theories of infantile sexuality and the dynamic unconscious. He may be forgiven for concentrating so exclusively on the core of his theory against the stern opposition from within and without the medical world. As he stated it, the opposition had good reason to be bitter. Copernicus and Darwin had robbed Man of his special place in the universe. His opponents battled his attempt to prove that they were not masters in their own minds. He recognized that the psychoanalysts were not the first to look inwards, but had supported their contentions by evidence which touched close to every man.

Adolescence

During puberty, the sudden resurgence of sexual interest is associated with maturation of the reproductive organs. The conflicts and solutions of the phallic stage are reinstated with libidinous energy. Unresolved conflicts of the oral, anal and phallic stages remain timelessly potent in the unconscious. The manner in which the id impulses have been controlled and object relations established (an "object" in Freudian terms is either thing or person) have a profound influence over the adult's attitudes towards friend and foe, those in authority over him and those under him, abstract ideas such as justice and loyalty, and material possessions; and towards men and women as sexual objects.

In a more dynamic sense, the freedom which the libido has obtained from the infantile aims and objects determines the amount of psychic energy which can be diverted from sexual gratification to do the bidding of the ego in social endeavours. Thus the libido is *sublimated* when a compromise between the forces of the pleasure-principle and those of the reality-principle is mutually satisfactory.

Dynamics of the Adult

The ego may be seen to have three main problems:

(1) Controlling unacceptable id impulses;

(2) Avoiding the pain of constant conflict with the id; and

(3) Achieving a harmonious synthesis of id, ego, and superego.

The demands of reality are at all times more or less inflexible. The ego must mould the personality to provide adequate satisfaction for the libido. As was mentioned before, Freud saw the function of the ego as being organizational and defensive. He was especially interested in the defences.

The main defence mechanism is *repression*. When you stifle the desire to correct someone's grammar or to rearrange their face, you do so consciously. This is a defence in that such action would not be in your best interest, but since you are aware of this, it is not a repression. Suppose that a girl is angry because her boy friend forgets to arrive for a date. She is able to forgive him sympathetically, but flies into a rage when her younger brother teases her. She herself is unable to identify the source of her violent feelings. She has repressed her hostility towards her friend into unconsciousness because it would be intolerable in conflict with her love for him. Repression is an unconscious process which can at the bidding of the ego, prevent thoughts or emotions from reaching consciousness.

The significant repressions date back to early childhood. The immature ego, unable to bear the frustration of sexual impulses or to satisfactorily sublimate them, can completely repress them, leaving them ex-

cluded from development under the reality-principle. The material repressed requires constant effort to maintain the repression. The neurotic is struggling with sources of infantile conflict and these can only be solved at the adult stage by the techniques of psychoanalysis.

The ego is essentially interested in the avoidance of pain. It represses impulses which are known to be danger signals, gaining therefore in two ways. Firstly, it becomes impossible for the impulse to be expressed as overt behavior. Secondly, potential anxiety which would be aroused by the dangerous impulses reaching consciousness is avoided.

Neurosis

Two dangers to the psyche may be seen in the genetic process, inhibition and regression. Portions of the sexual impulse may have an inhibited development, arrested at an early stage and still attached to the primitive objects of that period. This is a *fixation*. Portions of the libido which proceed further in development may *regress* when blocked and frustrated by external or internal forces. The stronger the fixations, the more easily will the later organization regress to them. The "object libido" may be likened to the pseudopodia of an amoeba which, when hurt by noxious stimuli, retract spontaneously into the mass of cytoplasm.

Regression without repression would produce perversion, not neurosis. There would be an adequate but abnormal and socially unacceptable gratification of the libido. When one adds repression the libido must seek circuitous outlets in which it will be disguised from the ego. There is a limit to the amount of unsatisfied libido a man can take on himself. It is not known what causes the variations in this ability, but when it is exceeded an outlet is found which satisfies the libido and the internal censor. The outlet is a neurotic symptom. The principle harm in a neurotic symptom is the amount of energy so uselessly expended and the mental energy lost in combatting it. Although the symptom satisfies the id, it is suffered by the ego.

Certain memories were found almost universally in neurotics concerning observation of intercourse, seduction by an adult, and castration threats. Freud, supported by his belief in phylogenetic memories, called these "primal fantasies" when he realized that all the reports he was listening to could not possibly be true. Why should some people indulge in such unconscious imaginings? Fantasy is a realm of the mind like a game preserve in which pleasure may be hunted with no restrictions from the reality-principle. Introversion is the term for the deflection of the libido from sources of real satisfaction to fantasies. The introvert is not neurotic, but unstable. When external sexual objects frustrate him there is an increase in libidinal attachment to the fantasies. This brings them closer to consciousness and stimulates repression as anxiety mounts. The economic approach to mental health recognizes that it is not only existence of potential conflicts but also the amount of energy focussed in the opposing forces which determines the nature of the illness.

Hysteria.

Freud found hysterics, one and all, to have repressed a most potent fantasy: that of the unresolved Oedipus Complex. The wish to love mother and the fear of castration had been repressed rather than handled by identification with the father. Repression of these infantile problems precluded adequate adjustments to reality. If regression occurred later the festering bed of infantile emotions could produce strange symptoms, like absolute prohibitions such as paralysis, blindness, anaesthesia, or a complete lack of emotions like love or hate. These symptoms are protective in that they prevent expression of the Oedipal desires. Freud found hysterics relatively easy to treat because they were quite well advanced at the time of fixation. They form a strong transference, the significance of which we shall soon see.

Obsessive-Compulsives

Here, as well, the Oedipus conflict is nuclear to the disturbance. The patient, however, has a fixation in the anal stage to which he regresses to avoid the fear of castration. These patients are often "anal" characters, as described.

Intolerable or foolish thoughts recur again and again. A devoted mother thinks of slashing her child's throat every time she sees a sharp kitchen knife. A girl washes her hair every hour yet still feels dirty. Freud was puzzled when he saw some of the real thoughts of the unconscious emerging until he realized that they were quarantined from their normal emotional content and mental associations. He called this Isolation. Many of these symptoms are designed to prevent hostilities from being recognized, or are an expression of the guilt aroused by the hostility. The symptom may be an attempt at undoing the damage which the child fancied he did in his stage of omnipotence.

Anxiety-Neurosis

Neurotic anxiety is the conscious emotional result of frustrated libido. The ego senses danger from the

demands of the libido and acts to frustrate the impulse. It must accept anxiety as the consequence. If the anxiety is too great it may be repressed and the libido allowed an outlet in a compulsion, or given restricted expression in an obsession or phobia.

Psychosis

Schizophrenia was known to Freud as Dementia Praecox. He considered it to be a regression to the narcissistic state. Freud saw the delusion of grandeur as similar to the overestimation of the "object" in a love relationship. But in this case all the object-libido is withdrawn and focussed on the self. Such a withdrawal is not necessarily pathogenic but occurs every night as a necessary prerequisite to sleep when we completely dissociate ourselves from the world. However, in dementia praecox the libido is forced to leave its objects, by a form of repression. It reverts to the stage of fixation, primary narcissism. The attempt by the libido to reach its objects conjures up delusions which are at best fantasied representatives.

Freud could give no better explanation. But his tools were of little use as the resistances of the psychotic are invincible.

Depression (Psychotic)

An oral fixation is postulated. The depression always follows the loss of a love object and the patient becomes as dependent as an infant. The dependency which the patient felt towards the lost one was accompanied by an equal measure of hostility. The punishment and expiation for this hostility is a prolonged grief reaction imposed by the harsh superego which this person developed because during the phallic stage he lacked the capacity for warm relations with his parents which would have modified their introjected image.

Therapy

Free Association

This is the basic technique by which unconscious material is brought to consciousness where it may be dealt with by the ego. Relaxed and sheltered from intrusions on the couch, the patient's repressed memories and patterns of behavior emerge with a freedom not to be found in normal conversation.

Dream Interpretation

Dreams are a valuable avenue to the unconscious. Indeed they are one of the main sources of proof that we have all passed through the same genetic process as the neurotic. The dreams of the neurotic are interpreted to him and form the starting point for free association. They also provide insight to the analyst. Dream analysis may seem ambiguous when applied to a single dream. It is not so when interpretted in the light of the free associations and general life pattern.

Life pattern

The reactions of the patient to the daily occurrences he reports to the analyst supply important insights to his unconscious conflicts.

The Dynamics of Therapy

The repressed memories which are causing the neurosis must be released. The emotions attached to these memories must be re-experienced in an "abreaction." The cure is to some extent a sort of catharsis.

Transference

The essential element is the transference, in which the patient reacts to the analyst unconsciously as to a father. Infantile conflicts are relived but the parent-substitute is able to show warmth and understanding which the patient can appreciate. Freud says: "In order to dissolve the symptoms it is necessary to go back to the point at which they originated, to review the conflict from which they proceeded, and with the help of propelling forces which at that time were not available, propel it to a solution. The decisive part of the work is carried through by creating . . . new editions of those early conflicts. . . ." The new struggle is worked out as a conscious mental conflict. Opposition between ego and libido is ended and libido is now at the disposal of the ego. The consciousness expands at the expense of the unconscious.

Resistance

The main difficulty in analysis comes from resistance. The analytic process may threaten a disguised source of gratification of the id; or the superego controls may be so weakened that the original anxiety which produced them will press for further buttressing. The ego acts under these forces to distract the analysis even though the patient is conscious only of a sincere desire to be cured. These resistances provide the analyst with valuable knowledge about the nature of the repressed material.

Working Through

A very important aspect of therapy is the recognition that cure is not provided by a flash of insight. Rather, a detailed and repetitive working through of all aspects of the neurosis is necessary to permanently

dispel the fixation and free the libido from its infantile chains. The aim of psychoanalysis is thus seen to be a fundamental change in the personality so that the patient, released from his neurotic hangover, can confront the problems of life realistically.

Finally, Freud recognized that the analyst, too, has an unconscious, and would invariably form a relationship with the patient, the force of which he must recognize. It is essential that the analyst be analyzed himself, to help him recognize the bonds of his own libido.

Comment

I regret that this outline is not more concise and clear. I will not be surprised if I find that I have passed on misunderstandings to you who have struggled thus far with me. There seem to be difficulties beyond the problem of terminology which make it hard to grasp the full meaning of what Freud had to say. These derive partly from the abstract quality of his concept of libido and how it is attached to its various objects and partly from the obscurity of the ego. Wide reading in the field seems to be essential for a comfortable grasp of psychoanalysis.

Admitting these problems, what can we say about the impact of Dr. Freud? His explanation of the production of neurotic symptoms fits many patients accurately. He has expressed a number of truths about human nature, sick or healthy. His theories are supported by impressive evidence and his therapy by many good results.

But the majority of neurotics show features which are not adequately explained on the basis of infantile sexuality. Freud de-emphasized many potent forces which play on the psyche. The influence of the group on the individual, the importance of intellectual development and of the person's view of himself, cannot be denied. Also, psychoanalysis is slow and expensive and distressingly often fails to cure.

We must try to appreciate Freud's work as though we came from another century. He gave us valuable insights. He stimulated work in a difficult field and produced the first real psychotherapeutic tools. He opened a new chapter in the search for knowledge and his failures only serve to provide us with a reminder that psychology is still an infant.

Book Review

Pediatric Psychiatry; Hale F. Shirley, 1963. Harvard University Press; in Canada, S. J. Reginald Saunders and Company Ltd. 796 pages. $10.00.

Pediatric Psychiatry is a successor to Dr. Shirley's earlier book, *Psychiatry For The Pediatrician*. It is not, and does not claim to be, a definitive volume on the fairly recent subspecialty of child psychiatry. It is directed primarily toward the pediatrician and the conscientious general practitioner rather than the practising psychiatrist. While defining common psychiatric terms, it is written in language easily understood by the nonspecialist, and it presents clinically useful knowledge in the field of child development as well as procedures necessary for effective management of the emotional and behavioural disturbances of children. The material of the earlier volume has been completely reorganized, rewritten, and updated, and there have been extensive additions made to the earlier text.

The book is divided into four sections. Part I is specifically "designed to help the preclinical medical student integrate his growing knowledge in the basic medical sciences into concepts of human development and behaviour." But this section is certainly of much wider interest than has been indicated by the publishers, presenting as it does an excellent summary of the factors and psychology of early development. Part II deals with the periods of childhood, from infancy through adolescence, and it is intended to be useful in well-child care. In Part III, special attention is paid to the emotional and social aspects of the various clinical problems, such as mental retardation or physical handicap, which frequently confront the pediatrician. Part IV discusses diagnostic and treatment procedures which are suitable for general pediatric practice, but techniques employed in child psychiatry are also described with a view to giving the reader some idea of the procedures used in the higher form of therapy.

In short, this book is an interesting, well-written, informative work of more than usual worth to all those who will eventually be dealing, even if only occasionally, with the younger members of our society. *S.P.B.*

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Psychoanalysis, Part II: The Post-Freudians

by Sam Izenberg

It may at first seem antinomous to be discussing non-Freudian schools of psychoanalysis, when one considers that the original meaning of the term psychoanalysis as conceived by its creator, Sigmund Freud, was his own unique system of explanations of psychic symptoms in terms of certain repressed impulses. Of essential importance, of course, to this system was his 'libido theory' "loosely defined as an emphasis on infantile sexuality, or on any native biological drives." Indeed except for C. G. Jung, the one feature which the non-Freudian schools share consistently is an active and at times bitter rejection of Freud's singular emphasis on infantile sexuality in personality formation, and in the unconscious dynamics of adult function.

This apparent contradiction is, however, resolved by broadening the term psychoanalysis to include all systematic efforts to probe the mind by scientific methods. The justification for this dilution of the term lies partly in the fact that this wider concept is the working concept generally taken for granted by the layman, and more importantly, it is seen that in actual practice — in the encounter of analyst and analysand — the different theoretical constructs often melt away as the individual proponents of the various schools attempt to grasp the situation of the individual facing them.

Furthermore, certain basic attitudes in one form or another are accepted fairly universally by the various schools — psychological determinism (i.e. a rejection of the idea that behaviour is accidental), unconscious forces affecting overt behaviour, motivation and dynamics (the concept of goal directed behaviour), and the concept that the significant psychological patterns in the adult are a product of his adaptive experience.

The necessity of choosing among the various schools, dictated by space, is certainly unfortunate, as many significant and unique points of view must be omitted. Adler and Jung are included because they were disciples of the master, and their divergent orientations are, therefore, particularly significant. The impact of their respective systems will be understood more clearly after the systems have been presented. Erich Fromm and Karen Horney are contemporary psychologists whose socially oriented systems are representative of the current trend to a shift in emphasis by examining man in his culture — in terms laymen can more easily cope with.

An attempt has been made here to present each school as an unified comprehensive system focussing on its views of man the organism, environmental factors, and the dynamic processes operative within the individual. Comparisons of salient features in the varying schools will be made to delineate more sharply the various emphases and unique features of each.

Finally, mention is made of the school of Existential Analysis, which is becoming increasingly important in North America following its rise to prominence in Europe. It, however, requires a unique treatment, for it cannot be classified under the same headings as the schools previously mentioned.

Alfred Adler (1870-1937) was the first of Freud's original disciples to break with the master. To distinguish it from Freud's system, "Psychoanalysis", Adler called his set of ideas "Individual Psychology", and the most significant feature of it, is the emphasis it placed on the total person as a goal-directed unit in contrast to the Freudian fragmentation of the psyche. But Adler, too, conceived of a universal experience which is the ultimate core of the total strivings of all individuals. The biological root of this universal, is the helplessness of the human infant as faced with powerful adults and uncontrollable forces and structures. This feeling of helplessness inevitably gives rise to normal and universal feelings of inferiority, and these, he early postulated, call forth compensatory drives to superiority. Adler then turned to a source which is inconceivable to this writer, and found three attributes — social feelings, courage, and common sense — which he considered to develop automatically as the native potential of man growing in a good human environment unless positively thwarted. These attributes convert the drive to superiority into constructive striving or social interests.

In emphasizing the total person, Adler was led to a close examination of the "life style" of the individual, his behaviour, dreams, and job attitudes, to understand the specific goal of the individual and his mode of reaching it. In this, Adler led the way for stressing not only neurotic components of a person's life to understand him, as Freud mainly emphasized, but every aspect of his normal existence.

For Adler as for Freud, the early years, one to five, are vital, for each person has a goal which is uniquely his own, and he adopts early in life his own particular technique for reaching it. Specific organ defects, interpersonal situations which may create particularly deep

inferiority feelings, will focus the strivings into a particular pattern. If a child comes to feel entirely helpless he may attempt throughout his life to gain support of others in order to maintain himself or assert his will, perhaps by developing certain handicaps which win him sympathy and protection. Conversely, if the child feels that the world is hostile and allows him only that which he coerces, he, therefore becomes overly aggressive and mistrustful.

Adler focussed particularly on interfamily relationships, and saw that there were types of family situations which set characteristic problems for the child and evoked characteristic solutions. The pampered child does not learn to master situations but instead continues to expect total support and absolute superiority in his encounters. Similarly, the dynamic mechanisms of the relationships of the hated child, the firstborn, the second, the youngest, are all outlined with a view to the typical goal and patterns they produce. Much cocktail psychiatry has unfortunately been strained from many of Adler's keenest observations and it is often amusing to see the intensity with which one of Adler's concepts, the inferiority complex, is discussed by the simple. Adler emphasized, much less comprehensively, broader social factors.

In terms of the actual functioning of the mind, Adler stressed the life style as the effort to compensate for inferiority. Thus, dreams are useful creations integrating immediate structures in terms of the enduring life style. They are only harmful if social feeling is weak for then they widen the gap from reality. He utilizes the mechanism of unconscious function but does not believe in a real dichotomy between the conscious and unconscious per se. The life style is unconscious in terms of the choice of behaviour to achieve a goal, but there is no active repression of potent single factors, acting in isolation against the overall direction. Adler rejected interpsychic conflicts and saw conflict as always being between the life style and goal of the individual, and the forces in the external world preventing their fulfillment.

Adler's particular genious has been his insights into some personality types, the effects on personality of intrafamilial relationships, and new pathways for the examination of the psyche. His total system, however, seems too limited and inadequate to be more than an explanation of the manner in which psychic problems develop in some people.

Karen Horney (1885-1952), a German analyst, came to America with the rise of Nazism and has since had a profound effect on the American scene through her works "New Ways in Psychoanalysis", "Our Inner Conflicts", and "Neurosis and Human Growth", and her part in founding 'The Association for the Advancement of Psychoanalysis' and 'The American Institute of Psychoanalysis.'

Like Adler, Horney was concerned with the whole personality and rejected Freud's instinct theory and his psychic structure. Like Adler, too, she singled out one factor as basically determining for human patterns, and again this factor is the helplessness of the infant. However, here she leaves Adler for she rejects the necessity and universality of the feeling of inferiority or defencelessness as a resultant of the infant's helplessness; rather this condition is the central one for neurotic development if real difficulties in the world outside the infant become threatening or hostile. Furthermore, unlike Adler's emphasis on a focussed sense of inferiority leading to compensatory superiority drive, Horney believes that the infant's helplessness leads to a heightened need for security. This is the central need of all neuroses and is filled by neurotic "safety devices". Exorbitant longing for love is an obvious search for the safety of support; submissiveness and altruism may be direct requests for protection or defences against violent self assertion which would invite retaliation.

For Horney, a neurotic person is one who is more rigid in his modes of reaction and less perceptive as to the real threats of situations. His reactions are determined by his family unconscious neurotic needs and are, therefore, inappropriate. Neuroses are always matters of degree. She divides neuroses into two types — the first is "deep neuroses" which stem from a pathological childhood, in which the child's fearfulness and need for security have been exaggerated ,and therefore his emergent psyche is crippled in its ability to respond flexibly to new situations, such as his entry into school, an anxiety-provoking situation even in essentially normal, well-developed children. The second type is the "situational neuroses", wherein an essentially normally developed person breaks under intolerable strain from present circumstances. Thus for Horney the early childhood is vital as a factor only in the cases of deep neuroses. Moreover, Horney is systematic in her treatment of cultural forces and their effect on the individual — particularly focussing on conflicting values, such as altruistic brotherly love as opposed to personal success and possessions.

In terms of dynamic functioning, Horney, unlike Alder, retains the outlines of Freudian repression. She sees certain aspects of the personality as repressed becaue they produce unbearable anxiety; for example, anger and insults may be repressed and manifested as

depression if the anxiety caused by the anger, i.e., the fear of retribution to the anger, is great.

This intrapsychic conflict clearly differentiates Horney from Alder who objected to this disunity of function. The conflict only appears as a consequence of social mishandling which institutes exaggerated impulses such as the hostility previously mentioned and fears of retribution, in contradictory directions, and to exaggerated degrees. Thus a 'vicious circle' develops as in the person for whom the neurotic solution to an excessive sense of helplessness is an excessive need for affection, a need which can't be filled thereby exacerbating the anxiety and the neurotic drive to relieve the anxiety. Basic personality types emerge as mechanisms for seeking safety — wherein aggressiveness, compliancy, or detachedness are the predominant features — all harbouring the type of vicious-circle conflict envisaged above.

Finally, Horney emphasizes a drive in individuals for a sense of unity and integration. To achieve this, an unreal, idealized self image is built and unharmonious aspects strongly repressed. Even when this repression is successful, the personality experiences alienation from the self, feelings of futility and emptiness. At the end of her career, Horney conceived of the tension between the self image and the real self as the central conflict in all neuroses.

Horney's main contributions have probably been her clinical insights into pathological processes active in individuals, manifested as neurotic behaviour patterns. The question of the primary aetiological factors of the pathology is left largely untouched because she circumvents the complex interactions of the many subsystems operating in the individual. As a result her system of psychology remains incomplete.

Erich Fromm is the most popularly read of any of the analysts discussed here. His broad themes have been social problems; however, he has focussed them on the analysis of the individual as a determining unit in social forces.

Fromm believes that although man originated as part of instinctual nature, he has transcended it, while at the same time never really leaving it. He can, however, never return to an instinctive existence for he is human and is faced with all the uncertainties that this signifies Man has reason. "He is life being aware of itself", he is aware of himself, of individuals outside himself, of his past, his potential future, his short life span, his impending death before his loved ones, or their deaths before his. Thus he cannot but be aware of his essential aloneness and helplessness in the face of the tide of events and people. This experience, therefore, leads unquestionably to deep anxiety feelings. Fromm, therefore, unlike Horney, believes that a measure of anxiety is universal, and the desire to relieve it, in an 'escape from freedom', is a normal one which must be commonly resisted. So, for Fromm too, neurosis is a matter of the degree to which the individual copes with the feeling of separateness in a non-productive mechanism of escape.

The preceding ideas necessitate an examination of what were for Fromm the healthy and unhealthy methods of dealing with this feeling of isolation. "He would become insane could he not liberate himself from this prison and reach out and unite himself with the world outside" . . . "to achieve union, how to transcend one's own individual life and find one-atment"[1].

Fromm suggests that a certain group of answers are consistently employed to solve this problem. One method is the inducing of orgiastic states. This may be seen in many rituals of primative tribes — where they are auto-induced or aided by drugs. In the brief state of exaltation the outside world disappears and therefore the feeling of separateness from it. In non-orgiatic cultures, alcoholism and drug addiction are the corresponding methods. However these generally provoke feelings of guilt and remorse thus exacerbating the original problem.

With the enlargement of societies, union with the group, indeed submergence in the group has become the predominant way of ending separateness. "If I am like everybody else, if I have no feelings or thoughts which make me different, if I conform in custom, dress, ideas, to the pattern of the group, I am saved; saved from the frightening experience of aloneness"[2]. Equality in society has come to mean 'sameness'. Women have become equal because they are not different.

A third way of attaining union lies in creative activity wherein the creator plans, produces, and views the end product, unlike the assembly-line worker, or clerk. However this is only a partial solution for the union is not interpersonal.

Fromm says that the full answer can only be in interpersonal fusion — in love. By this he does not mean a symbiotic union wherein two people fill specific needs in each other and lose their integrity in their total dependence on each other with the frequent formation of masochistic-sadistic relationships. Rather Fromm's concept of love is "a union under the condition of preserving one's integrity, one's individuality." Love is an active process and always implies the basic elements — care, responsibility, respect and knowledge. Furthermore, "above the existential need for union, rises a more specific biological one: the desire for

union between the masculine and feminine poles." Thus the ultimate answer to the universal need is a true love relationship between a man and a woman.

In functioning terms, Fromm stresses the interrelation of individual character and social ethics. In general a child acquires the character that allows him to operate in his particular social setting. However, if the demands of living outstrip the individual's increasing growth in strength, he attempts to reassert his primary relationships in an escape from the freedom of the self.

Finally, Fromm has developed a new concept in his relation of specific personality types to specific social-economic patterns — i.e., receptive, exploitative, hoarding, marketing, and productive personality types.

Fromm's socio-psychological interpretations and his stress on man's existential need to find meaning in life make him a particularly significant thinker for students of psychology, politics, and philosophy.

C. G. Jung: "If I change my concept of reality in such a way as to admit that all psychic happenings are real — and no other use of the concept is valid — this puts an end to the conflict of matter and mind as contradictory explanatory principles, Each becomes a mere designation for the particular source of these psychic contents that crowd into my field of consciousness."[3] Jung's phenomenological approach thus leaves him open to any event in the psyche such as religion, artistic expression, and philosophy, as valid expressions for the particular individual and as factors to be worked with in therapy. This is a radical break from the psychologies which claim that these concepts as not empirically analyzable must be explained away in other terms.

A further result of this approach is his acceptance of each school of analysis as potentially true for a particular patient's experience; hence his unhesitating eclecticism in his willingness to employ Freud's or Alder's techniques where he deemed them applicable.

However Jung did conceive of dynamic changes in the person with age, such that whereas Freudian and Alderian techniques are often useful before the age of forty, the transition occuring renders them relatively meaningless after this age.

"Experience shows us rather that the basis and cause of all the difficulties of this transition are to be found in a deep-seated and peculiar change within the psyche. In order to characterise it I must take for a comparison the daily course of the sun — but a sun that is endowed with human feelings and man's limited consciousness. In the morning it arises from the nocturnal sea of unconsciousness and looks upon the wide bright world which lies before it in an expanse that steadily widens the higher it climbs in the firmament. In this extension of its field of action caused by its own rising, the sun will discover its significance; it will see the attainment of the greatest possible height — the widest possible dissemination of its blessings — as its goal. In this conviction the sun pursues its unforseen course to the zenith; unforseen because its career is unique and individual, and its culminating point could not be caluculated in advance. At the stroke of noon the descent begins. And the descent means the reversal of all the ideals and values that were cherished in the morning. The sun falls into contradiction with itself. It is as though it should draw in its rays, instead of emitting them. Light and warmth decline and are at last extinguished."[4] Older patients usually suffer from the senselessness and aimlessness of their lives rather than from a definite neurosis.

Jung divides the course of the sun into four life stages, childhood till just after puberty, youth till about forty years, maturity, and finally senescence. Jung's particular contributions were mainly focussed on the third stage for he felt that the other schools coupled with his openness to all modes of expression handled the possibilities of the first two stages; and as for senescence, he felt it was almost a return to the first stage in the sense that communication about it from the individuals both in it and of course on their release from it was impossible.

Jung had a more comprehensive concept of psychic structure than anyone before or since. This structure is operative, of course, in the second and third stages. Firstly, he envisaged the libido as the energic life principle which shifts in specific focussing as the person develops. Basically the libido takes two directions, extraversion (outgoing, concerned with other objects and people, i.e., aimed at the 'outer world'), and introversion (concerned with the subject, the "I", i.e., aimed at the "inner world"). Both directions exist, but individuals tend to exhibit one attitude predominantly. Furthermore, Jung described four functions of grasping empirical material, sensation, intuition, feeling, and thinking. Ideally these work in harmony, but this is rare and usually two of them predominate. The neglected direction and functions are relegated to the shadow (the unconscious), where they gain in power as the one-sidedness of emphasis increases.

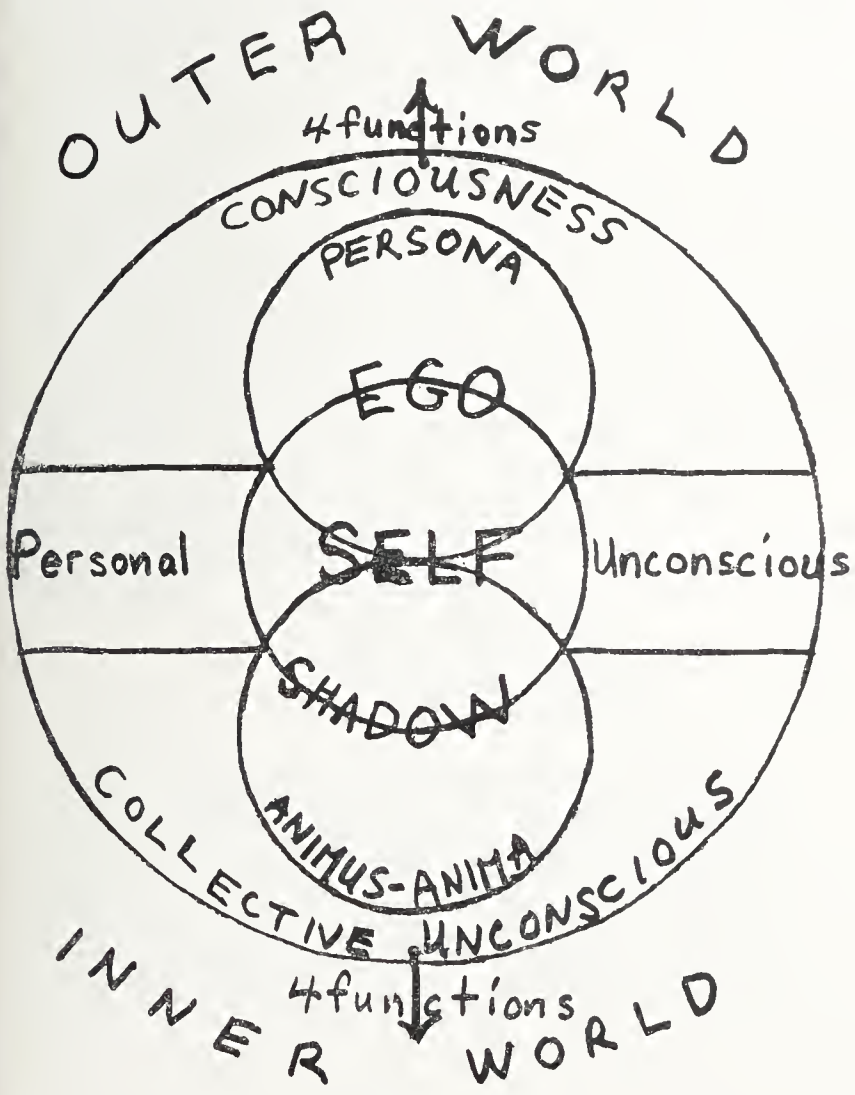
At work in the psyche also is the collective unconscious, "a certain psychic disposition shaped by the forces of heredity; from it consciousness has developed" . . . "the all-controlling deposit of ancestral experiences from untold millions of years, the echo of pre-historic world events to which each century adds an infinitesimally small amount of variation and differentiation."

These ancient systems show themselves as archetypes or images which express themselves as symbols, for example, the Mother as the life giver, the all-compassionate, the terrible punisher, the devourer, the divine harlot. These images are not inherited as such, but as previously stated are a result of dispositions to think in certain patterns.

In order to maintain a dynamic equilibrium, opposites of trends emphasized in the life of the individual exist as the unconscious shadow. This was previously alluded to in reference to libido direction and functions of empirical contact.

In each person there are bi-sexual tendencies. The contra-sexual counterpart of the sex of a given person is represented by the shadow force of animus or anima. An excessive rejection or identification with the shadow components leads to neurotic difficulties.

Ego-consciousness is Jung's term for awareness; for the vague sense of "I" felt toward inner and outer events. The "persona" is the "face we show to the world", the organized image of the self which is a resultant of adaptation to the world partly formed by specific ideals and goals. This construct of personality varies with the personality type as well as with the life circumstances. The extrovert often has several personae, for different situations. The persona is not the personality itself but only one aspect of it.



It must be stated here that the writer feels hopelessly inadequate to present in such a limited space the real multidimensionality and openness which characterize Jung. His far-ranging interests and integrative powers can only be hinted at, at best. Only Jung can really speak for Jung.

In order to balance the examination of psychoanalytic schools, mention must be made of threapy. However the actual treatment of patients as suggested by the various schools is far too involved and amorphous a subject to be handled in detail here. Obviously the aims and focussing of the treatment are derived from the theoretical constructs. The techniques employed are generally the same as those of Freud, i.e. free association, dream analysis, error analysis, observation of non-verbal behaviour etc., but different ones of these will be emphasized or omitted by individual schools, and indeed their interpretations of the significance of any one vary greatly. Furthermore in actual therapy, differences between the schools often become submerged, as the analysts do not attempt to force their theories on the patient, but rather attempt to work with the *individual* facing them.

"Yet all these [Freudian and non-Freudian schools] can't possibly warrant an adequate understanding of the psychotherapeutic processes. For none of them answers what ought to be the first and foremost questions: what would have to be the nature of such a "Psyche", such a psychic apparatus, such a human I or Self or total personality in order that something like a mere perception of an object, or of a human being, or even something like object relations and interpersonal and social relations can be at all possible? How should a telescope-like psychic apparatus or a self-regulating libidinal system be able to perceive or understand the meaning of anything, or to love or hate somebody?"[5] This rooting of psychological thereapy in basic philosophical therapy in basic philosophical questions has brought down much professional and popular contempt on the exponents of Existential Analysis. "What does philosophy have to do with psychological mechanisms, with exact empirical facts?" But this anti-intellectual fear of the bogeyman philosophy is totally absurd for there is no more philosophy in Existential Analysis than in the prescientific articles of faith of natural science, which are; that there is an external real world independent of man, that reality is only the sum of what can be measured and calculated, that the relationships between objects and events are always causal connections, and that everything real fits into the three dimensions of space, and temporal order. These are mere assumptions and are not pure facts. If therefore the analysis

of existence is more appropriate to an understanding of human reality than are the concepts of natural science, then Existential Analysis will be more scientific (i.e. "bringing about knowledge") than the behavioural sciences based on natural scientific concepts. This therefore leads into a discussion of the analysis of "dasein" (human existence) and of the types of problems Existential Analysis faces, as well as its psychotherapeutic applications. These vast areas are well beyond the scope of this article but it is hoped now that Existential Analysis will be studied and questioned on the basis of its postulates and validity of its claims, and not rejected out of hand as usless philosophy.

Implicit in the strivings of all the schools of thought is a recognition of the human obligation that man must search for an understanding of man. Without it he loses his distinctly human attributes and cannot advance creatively.

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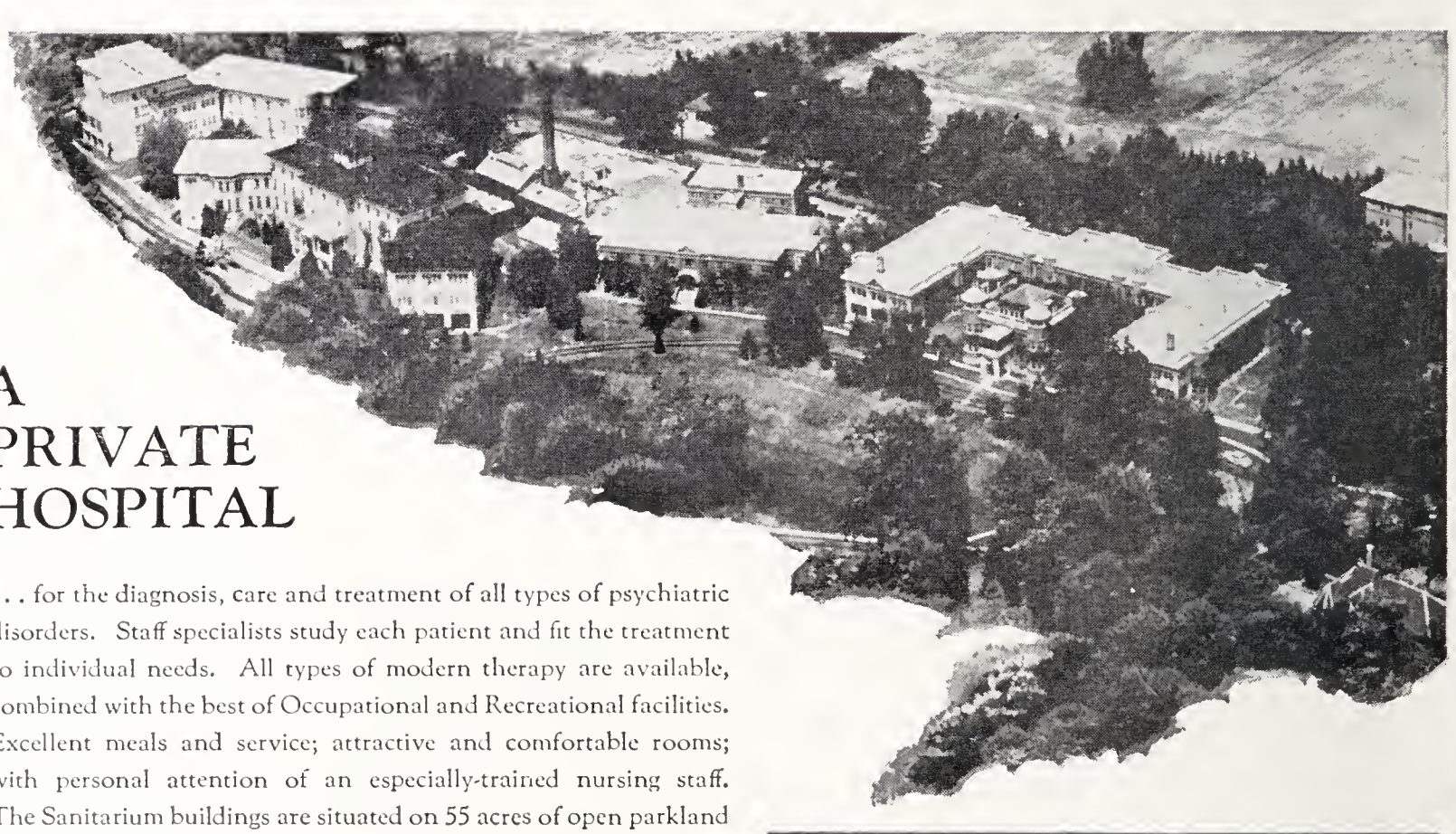

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Psychiatry and Religion

by G. S. Duckworth

"Know Yourself" — Socrates

To me, the most impressive achievements of man are not his nuclear devices, his space-rockets, or even his wonder drugs, but rather his tremendous efforts to understand himself and the world he finds himself in. This cognitive desire is the well-spring of all his conscious and unconscious creations, from his austere intellectual concepts and scientific theories to his ardent love for others. But the complexity of the objects of his cognition compel him to divide his cognitive attempts according to their object into relatively autonomous disciplines, thereby increasing greatly the possibilities for knowledge of each of the objects of study, but losing the ability to integrate his knowledge into a coherent whole. The result is the fragmentation of thought with which we are all familiar, and which tempts each specialist to claim for his specialty universal validity while denying the value of the arduous researches of others. Believing as I do that the human being is almost infinitely complex, and transcends in stature all attempts, conscious or unconsious, to imprison him within the confines of a thought-system, I repudiate as essentially dishonest the claim by a proponent of any one discipline to explain the fullness of a human being on the sole basis of the results of his researches.

It is particularly important for the phyisician who is called upon to minister to a sick person (not a disordered chemical complex) to possess a well-rounded approach to his patient and allow him to conserve his depleted energy instead of wasting it in trying to maintain his integrity in the face of the doctor's attempt to treat him as a fraction of his real self. Religion at its best has always cherished the diversity of man's faculties, believing that the gifts of God were meant to be used. In this secular society the psychiatrist has largely replaced the priest as a therapist for the psyche, and to him, therefore, falls the burden of maintaining as far as possible a harmonious cooperation among the various faculties of his patient. However, psychiatry as a tool lacks the homogeneity of religion, consisting of an uneasy blend of two approaches: a pragmatic and a theoretical. I can see no way of discussing in the same breath the use of Largactyl and the union of the soul with God nor do I see any point in discussing measures which are purely pragmatic, and which therefore cannot be used with any knowledge of what one is doing. Since the psychiatrist, insofar as he know what he is doing, relies on the theories and techniques of psychoanalysis, I think it most profitable to discuss the relation between the latter discipline and religion. My remarks are directed as follows: firstly, an analysis of the contributions of Frued and Jung; secondly, compared and contrasted with them, the great religious thinker Dante; thirdly, some words as to the roles of the two disciplines in therapy.

(A) *Freud*

Freud was the founder and chief proponent of the libido school of psychoanalysis. His theories may, for convenience, be divided into two groups: firstly, his analysis of religion, poetry, and art; secondly, his theories of psychical structure.

To Freud,* human culture is dual in nature, including on the one hand all the knowledge and power that men have acquired to bend nature to their needs, and on the other all the arrangements for the distribution of riches. For this to be possible, culture demands and enforces a certain renunciation of individual instincts which became fixed in early childhood, creating in reaction a hostility on the part of the masses to culture itself and to the leaders that enforce its demands. Some of the renunciations, namely those of incest, cannibalism, and murder, have become deeply internalized in the form of the superego, but others are still felt to be alien commands obeyed only out of fear of punishment. It is for this reason that the satisfaction of ideals and art were created. Ideals are modelled on the first achievements of communality by the culture, held fast as examples to be followed. They thus afford all members of the culture a narcissistic satisfaction of pride over past achievements and contempt for other cultures which is a potent force binding even the downtrodden members of the society into a self-adulatory unity with the leaders who now emerge as the quintessence of their ideals. Similarly art both affords substitutive gratifications for the oldest, and hence most deeply felt cultural renunciations, and also promotes feelings of identification by so representing the cultural ideals as to subserve a narcissistic gratification.

*The Future of an Illusion.

However the repressed hostility against culture still remains, in spite of its undoubted protective value against unconquered nature which rises against us sublime, pitiless and inexorable. In the face of the imperilling of man's narcissism by the threat of fate, culture again steps into the breach and robs nature of its terror by humanizing it. Helpless against the impersonal forces of life, man is now offered the seductive prospect of being able to control these forces, conceived of as wholly personal, by appeasement, exorcism and bribery. This situation has its prototype in the relation of the helpless infant to its omnipotent father. As natural laws are discovered and the face of the cosmos depersonalized, the father-gods retain their triple task: to reconcile man to the cruelty of fate, to exorcise the terrors of nature and to make amends for his instinctual privations. But the accent begins to shift: nature becomes more autonomous, and the work of the gods becomes restricted to morality i.e. to the work of adjusting the evils of culture and enforcing its laws. The conviction remains that life has a higher purpose: the perfecting of human existence by the intention of a superior Intelligence who orders all for good (i.e. to our own advantage) if not in this world then in one after death.

The *historical origins* of religion are to be traced to the dawn of mankind when people lived in the primal horde i.e. a small group of women and children led by a dominant male, the father of the tribe, who jealously kept all the females for himself and drove away the growing sons. One day the expelled brothers joined forces, slew and ate the father, and put an end to the father horde. The brothers identified themselves with the dead father and hence with each other by the cannibalistic totem-feast which commemorated that criminal act with which so many things began, social organization, moral restrictions and religion. But they had gone too far: their ambivalent feelings towards the dead father created an intense remorse, resulting in the undoing of their deed by forbidding both the killing of that father-substitute, the totem animal, and also the possession of the liberated woman. The totem religion thus issued from the sense of guilt of the sons as an attempt to palliate this feeling and to conciliate the injured father through subsequent obedience. All later religions prove to be attempts to solve the same problem, varying only in accordance with the stage of culture in which they are attempted and the paths which they take; they are all, however, reactions aiming at the same great event with which culture began and which ever since has not let mankind come to rest. The god is at bottom nothing but an exalted father. Palliation for the ever-present sense of guilt was achieved by transference to a sacrificial animal, which was then slaughtered as an offering to the god. But the guilt and defiance of the son did not rest but increased continually, until in Christianity the son atones for his primal murder with his death and subsequently replaces the father-god by being enthroned in heaven. As a sign of the substitution, the totem-feast was revived in the form of the Communion. Therefore, Freud concludes, the beginnings of religion, ethics, society and art meet in the Oedipus complex.

The *contents* of religion are certain dogmas, assertions about conditions internal and external which tell one something that one has not oneself discovered and which claim credence. This claim is to be rejected: there is no appeal beyond reason. Of what significance is it for other people, asks Freud, that you have won from a state of moving ecstasy an impeturbable conviction of the real truth of the doctrines of religion? Truth must be common to all. Religion brings with it obsessional limitations, but scientific work is our only knowledge of external reality, as its numerous and significant successes have shown. The voice of the intellect is a soft one but it does not rest until it has gained a hearing. Ultimately, after endlessly repeated rebuffs, it succeeds. Science is no illusion. But it would be an illusion to suppose that we could get anywhere else what it cannot give us.

My basic criticism of the foregoing views is that they are oversimplified. The genetic endowment of the child is not restricted to sexual needs but includes a multitude of factors: needs for motility, sensory stimulation (e.g. visual), nutrition, warmth, human companionship and love, to name but a few. Freud's excessive fixation upon the Oedipus complex which he projects on to all men completely misses the point. The *central* problem of man is not sex, but rather that of finding himself in an alien universe ("I a stranger and afraid in a world I never made.") and of self-preservation in the face of a hostile world. Therefore the most vital activities of man are firstly, to learn the nature of his environment; secondly, to defend himself against it; and thirdly, to maintain against all shocks a self to preserve — in other words science, dominance and self-integration. It is because Freud neglects the secondary nature of sex that his theories of development stop in the nursery (about six years) with the first quasi-solution of the problem of the Oedipus complex, and then begin to repeat themselves endlessly. The "latent period" (6-12 years) is hardly even mentioned; adolescence and old age are merely the struggle with repressed infantile sexuality. Man is too complex to be enclosed within the narrow compass of such a theory.

(B) *Jung*

A man of immense subtlety and erudition, Jung does not fall into the same trap as Freud. For him the human being is a tremendously complex organism which he does not pretend to understand. But in order to attempt the task, he uses all the tools at his disposal: a subtle philosophic mind, a long training in science and psychoanalysis, a sensitive religious insight and an impressive erudition. Jung's criticisms of Freud are threefold: firstly, psychological knowledge is not of universal absolutes, as Freud thought, but is highly subjective. All theories (including his own) reflect chiefly the mind of their creator. Freud's concepts were the truest expression of his own psychic make-up, and apply to many men, but not all types of men are adequately described by them. Secondly, his theories are pathological insofar as Freud interprets all society (from the primal horde onwards) in terms of concepts derived from the neurotic states. This is not a psychology of the healthy mind. Thirdly, Freud's psychology is based upon a view of the world that is uncriticized or even unconscious, and this narrows his understanding and experience. Freud does not realize how much the Oedipus complex owes to his own psyche and to the Viennese society of his day. He explained away all that is radiant in man even when the explanations were inappropriate. It was a great mistake on Freud's part, says Jung, to turn his back on philosophy. Not once does he criticize his premises and assumptions. "Do you suppose" asks Freud "that men's thought-processes have no practical motives, that they are simply the expression of a disinterested curiosity? This is surely very improbable." "How unfortunate my dear Sigmund!" Jung replies, "I had hoped that your theories were disinterested, but it now seems very improbable that they are. Their meaning must lie in your irrational beliefs, such as your naive faith in science. Furthermore I've always thought that your "superego" was rather a subtle way of insinuating your "Jahweh" into psychoanalysis, and all that sexual theory is somewhat suggestive!"*

Philosophy, for Jung, was a way of freeing oneself from the naive acceptance of the popular attitude of unreasoned, not to say emotional, surrender to the all-importance of the physical world. To Jung it is no more logical to say that the psyche is a biochemical phenomenon than to say that the dance of electrons is a manifestation of the creative spirit of life. We have just discovered that our forefathers had no right to assume that man possessed an immortal soul which supported the life of the body, but we have not yet discovered the presumption of assuming that hormonal secretions of the brain produced Kant's Critique of Pure Reason. Jung therefore changes his concept of reality to mean that all psychic happenings are real and no other use of the concept is valid. This puts an end to the awkward dichotomy between mind and matter by pointing out that they are both mental contents. Jung therefore accepts all manner of gods provided only that they are active in the human psyche — sexuality, or will to power, or spirit. "I am far from knowing what spirit is in itself, and equally far from knowing what instincts are. The one is as mysterious to me as the other, yet I am unable to dismiss the one by explaining it in terms of the other. That would be to treat it as a mere misunderstanding." For this reason he attributes positive value to all religions. In their symbolism he recognizes the dreams of his patients, and in their teachings the results of their efforts to deal with the forces of their inner life. "In my picture of the world there is a vast outer realm and an equally vast inner realm; between these two stands man, facing now one and now the other, and, according to his mood or disposition, taking the one for the absolute truth by denying the other." Great poetry gives expression to this vast inner world and rends the veil of the commonplace behind which we hide in protection from it. The poetry of Dante is of this quality.

(C) *Dante*

"Midway this way of life we're bound upon,
I woke to find myself in a dark wood,
Where the right road was wholly lost and gone."

The opening words of Dante's Comedy plunge us into the middle of his life when he suddenly becomes aware that he has left the path of right living and finds his life a tangled, smothered jungle. The Comedy is to be interpreted on four different levels simultaneously, of which I will consider only one — the personal. Thus, it is the story of Dante's life as he saw it; it is the stages of his increasing self-knowledge; it is the path of all men's psyches as they strive for union with God.

He had stumbled from the right road, Dante says, in a state of unconsciousness in which the bitterness and roughness of the forest (his life) did not impress themselves upon him. He sees before him in the morning sun a mountain (the way to God) with a straight path running up it, and toils to ascend it, only to find his way barred by three archetypal figures. Firstly, a dappled leopard gambolling in his path (the sins of youth, of incontinence) forces him backwards; then a savage lion (the sins of maturity, of violence) menaces his path; finally, a ravening she-wolf (the sins of old age, of malice) drives him back again into the

*When we have a toothache we can think of nothing else.

lightless forest from which he had just emerged. In the anarchic state of his mind, these fragments of his darker being are autonomous and split off from his intellect. As he stumbles down the path an awful spectre looms before him. It is Virgil, the master of poetry and singer of the building of Rome (he represents human art, virtue, knowledge and wisdom. He stands also for Community). He is come, he says, to guide Dante through Hell to Purgatory from whence he shall see God. "But I'm not fit to go there" Dante protests. "I'm not Aeneas and I'm not Paul." "If I have grasped what thou dost seem to say" replies Virgil looking hard at him "these doubts breed from sheer black cowardice". Of course they do. It is a painful experience for all of us to see ourselves as we are, and we resist the attempt to make us aware of the depths of our psyches. To cure this fear, Virgil tells him that a lady from Paradise (Beatrice — Dante's beloved, Religion, love and consideration for others) had begged him to save her lover. At this, Dante's courage returns, and he becomes eager for the quest. (Before we descend, with the aid of another, into the depths of our minds we must be assured that his intellect is motivated by genuine consideration for us).

They come to a great gate on which are written the words "Eternal Justice and the Primal Love that spreads itself throughout creation consigned me to everlasting night: abandon all hope ye that enter herein". Dante turns in sudden fear to Virgil, but the poet replies "We've reached the place I told thee to expect, where thou shouldst see the miserable race of those who have lost the good of intellect". In other words, they are approaching the irrational parts of the mind where reason's threefold function: of correlating the knowledge of its various parts, of knowing reality and of ruling the psyche, have all disintegrated. They pass through the gates, and immediately their ears are assaulted by

> "Tongues mixed and mingled, horrible execration,
> Shrill shrieks, hoarse groans, fierce yells and hideous blether
> And clapping of hands thereto, without cessation
> Made tumult through the timeless night, that hither
> And thither drives in dizzying circles sped,
> As whirlwind whips the spinning sands together."

This is the Vestibule where the futility that refuses to choose for good or for evil, but vacillates like the wind, is housed. A human being must choose and, refusing this choice, these people lived as vegetables and neither Heaven nor Hell, which are built for men, will accept them. The ground belches fire and Dante faints. He wakes to find himself already across Acheron in Limbo, the region of ignorance of the right path, where unaided reason dwells.

> "We heard no loud complaint, no crying there,
> No sound of grief except the sound of sighing
> Quivering for ever through the eternal air."

They descend to the next circle where a howling black wind whirls the souls of men in the sweep of its swath like starlings in a winter storm. This is the circle of lust, where reason is blown on the winds of passion. Dante swoons for sympathy and wakes to find himself in the next circle, that of gluttony. Here the mutuality of lust is gone and only the solitary wallowing in one's own sensuality is left, like ". . . rain

> One ceaseless, heavy, cold, accursed quench,
> Whose law and nature vary never a grain;
> Huge hailstones, sleet and snow, and turbid drench
> Of water sluice down through the darkened air
> And the soaked earth gives off a putrid stench".

He passes to the next circle where the hoarders and spendthrifts roll great rocks against each other. Mutual indulgence has already declined into sefish appetite; now, that appetite becomes aware of the incompatible and equally selfish appetites of others. Indifference becomes mutual antagonism. He passes a marsh where the wrathful gurgle their hatred in the mud like bubbling lava. Until this point Dante's descent (and ours) has been unconscious and imperceptible, but as antagonism turns to hatred, the steps of the downward path begin to be fearfully apparent. From this point on the descent is mapped out with inexorable clarity — the image of our souls bent on their own destruction clambering stubbornly down all the foulnesses of our inner hells.

Dante and Virgil are ferried across the marsh and reach the gates of the great walled city of Dis, nether hell (the sins of the lion). Virgil demands admittance, but unexpectedly he is repulsed and the gates of the city clang shut (reason is always apt to underestimate the deliberate will to evil). On the battlements a horrid figure appears — Medusa (the image of despair) — and Virgil quickly whirls Dante around so that the dread figure will not turn his heart to stone. Behind them the dark air whirls in storm; before them the iron walls of the city of discord glow with a sullen red heat. They are helpless. But through the foul air a great Being strides. Walking on the waters, unmoved by the noisome vapors, except that his hand gently fans away the odors, the messenger touches the gates of the city which spring open unresisting, then turns and goes upon weightier errands. They enter the city, pass down the circles of the violent; the wood of the suicides where

the violent against themselves enjoy the fruits of their dispossession by growing like trees, the violent against others, art, and God lying on the abominable sands under a snowstorm of fire, to the edge of a great cliff down which they cannot climb. Virgil takes Dante's rope girdle, with which he had hoped to catch the leopard (some vow of chastity) and throws it over. In response a great beast rises to greet them: his face was like a just man's, his body like a reptile shimmering with the rainbow's hues, and his tail was that of a scorpion.

> "Behold the beast with stinging tail unfurled,
> That passes mountains and breaks weapon and wall;
> Behold him that pollutes the whole wide world."

They descend to the depths of hell on the back of that unclean image of Fraud. This last region of hell (the sins of the wolf) is divided into two parts by a well: Malbowges, the region of fraud simple (deception of those who have not trusted us) and fraud complex (deception of those who have confided in us). Malbowges is divided into ten bowges, where those who falsify sexual relations (seducers), justice, religion, possession (thieves), money (forgers) and words are to be found. Here we find the harlot Thais who, when her lover asked her whether he had earned her thanks, lied "O marvellously". Because she falsified words, the mirror of truth and the means of expression of love, she wallows forever in the filth which she excreted upon the world.

They reach the well of fraud complex, and are lifted down by giants, the images of the primitive blocks of mass emotion which remain when the intellect has been wholly corrupted. They mouth nonsense-syllables, for language is now so corrupted that it is no longer a means of communication. They land in the well, where the traitors to their kindred, country, guests and lords, lie in a sea of ice, moving only to gnaw each others scalps and brainpans. There, at the core of hell in that icy sea of pride, Satan, a great hairy monster, gnaws the souls of Judas, Brutus and Cassius, the betrayers of religion and community (Rome). Now Virgil leads him up a dripping tunnel in the rock, until they emerge once more into the fresh air and look upon the stars.

Dante came out alive only because his reason (Virgil) did not crack. In this he differs from many patients whose unconscious has achieved such autonomy that they need the reason of the doctor (Virgil) impelled by consideration for them (Beatrice) to save them. This difference is significant.

We have now seen the full extent of our corruption, but what can we do about it? That is the theme of Dante's Purgatorio, pictured as a great mountain 3,000 miles high which the soul must climb in this life to be purified. The purgative process consists of patiently enduring the sin or its opposite virtue. The purgation is directed at the threefold sin of man: love perverted (love of our neighbour's harm — pride, envy and wrath), love defective (apathy and indifference) and the excessive love of secondary goods (avarice, gluttony and lust). There on slopes of the mountain, bathed in the rays of the morning sun (the dawn of Love), we will leave them. We are all at this point in life: beginners in the way of Love. We will not presume to look into the glowing beauties of the Paradiso. That is the achievement of the very few, of whom this world is not worthy.

(D) *Correlation*

We have glanced briefly at two great systems of thought. Is there any possibility of integrating them or must we hold with Freud that art is an escape into phantasy, philosophy a shadowy system of seductive wiles, and religion a pernicious illusion? Jung and Dante provide us with a more unified and balanced approach to the problem. For Jung, all psychic contents have a claim to reality which cannot lightly be dismissed. The physician who tries to replace the patient's thought-systems with his own is merely compounding his sickness. Perhaps he will not greatly harm the younger person whose chief problem is one of directing his energies outward into a fruitful union with society, but to the mature or elderly man whose problem is that of withdrawing his energies, of evaluating his life and finding a self, such an approach would be catastrophic. In view of the fact that 57% * of Protestants in spiritual distress go to a doctor, whereas only 8% go to a clergyman, some sort of integration of the two professions is vital. One-third of Jung's cases suffer from no clinically definable neurosis, but from the senselessness and emptiness of their lives; whereas in the older age group (over 35 years) "there has not been one whose problem in the last resort was not that of finding a religious outlook on life, and none of them has been really healed who did not regain his religious outlook".

"What then" you may ask "is the essence of the religious outlook? What is this God so many seek?" Unlike Freud, I cannot give you a clear answer to this question, for I do not know myself. Let us listen, however, to the definition of a great mystic, Dionysius, of the object of his lifelong search:

> "Once more, ascending yet higher, we maintain that It is not soul, or mind, or endowed with the faculty of imagination, conjecture, reason, or understanding;

nor is It any act of reason or understanding; nor can It be described by the reason or perceived by the understanding, since It is not number, or order, or greatness, or littleness, or equality, or inequality, and since it is not immovable nor in motion, or at rest, and has no power, and is not power or light, and does not live, and is not life; nor is It personal essence, or eternity, or time; nor can It be grasped by the understanding, since It is not knowledge or truth; nor is It kingship or wisdom; nor is It one, nor is It unity, nor is It Godhead or Goodness; nor is It a Spirit, as we understand the term, since It is not Sonship or Fatherhood; nor is It any other thing such as we or any other being can have knowledge of; nor does It belong to the category of non-existence or to that of existence; nor do existent beings know It as it actually is, nor does It know them as they actually are; nor can the reason attain to It to name It or to know It; nor is It darkness, nor is It light, or error, or truth; nor can any affirmation or negation apply to It; for while applying affirmations or negations to those orders of being that come next to It, we apply not unto It either affirmation or negation, inasmuch as it transcends all affirmation by being the perfect and unique Cause of all things, and transcends all negation by the pre-eminence of Its simple and absolute nature — free from every limitation and beyond them all."

Whatever it is that Dionysius and others have found, the result of the discovery seems to be a complete integration of all the elements of their psyches into a complexly unique fabric, the "self".

Dante gives us a profound solution to this problem. Freud once wrote "If I cannot bend the gods on high, I will at least set Acheron in uproar." Coming, then, from the Limbo of Dante's Inferno at the request of Beatrice (Religion), Psychotherapy (Freud) is a representative of Virgil. Not the sole representative, for human wisdom also includes art and philosophy, but an important one nevertheless. His function (the function of the physician) is to guide the soul through the knowledge of his unconscious self (Inferno), past the gates of Purgatory (the working out of a more "normal" integrated life) to the Earthly Paradise at the top (the completely unified state of the psyche described allegorically as the primal innocence). There Virgil must leave the soul.

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In 1924, Louis DeBroglie developed the formula

$$\pi = \frac{h}{\overline{m\,v}}$$

π = Wavelength
h = Planck's constant
m = Mass of the illuminating particle
v = Velocity of the illuminating particle

Since h is a constant, and m for an electron is constant for most velocities, if v is increased then π will decrease. Thus, if an electron were accelerated by an accelerating voltage of about 60,000 volts, π would be about 1/40,000 the π for light. Thus particles 1/40,000 the diameter of those seen before could now theoretically be seen.

Early Instruments

First, emission microscopes were developed. In these instruments, a stream of electrons was accelerated by a high voltage and magnified as it passed through electrostatic or electromagnetic lenses and gave a greatly magnified image of the cathode itself.

This instrument was bypassed at first because only a magnified picture of the cathode could be viewed. This has, however, provided a valuable tool for metallurgists.

Later, transmission microscopes (generally used today) were developed to pass an electron beam through a thin specimen to project a picture of that specimen onto a fluorescent screen. H. O. Müller and E. Driest, working in Germany, were the first to develop an electron microscope whose resolution exceeded that of the best light microscopes. Rapid succeeding developments soon provided resolutions of about 10A°. Here improvement all but stopped and even today's best instruments provide no better than 6-8A° resolution under optium conditions.

Present Operating Principles

The present day electron microscopes are only very specialized cathode ray tubes. An electron gun at the top of an evacuated column, generates a cloud of electrons which is attracted by an anode a short distance away. The electrode operates at about 50-100 KV positive with respect to the cathode (actually, the anode and instrument are held at ground potential for safety reasons, and the cathode is held at a high negative potential). The high voltage accelerates the electrons which speed to the anode and pass through a small hole in the anode. The beam then passes down the evacuated column, through the specimen, through the electromagnetic lenses which magnify it, then it strikes a fluorescent screen or photographic plate.

Problems

Although the principles are simple, the electronic and mechanical problems severely limit the resolving power of this microscope.

Examples:

(1) The magnetic fields created by the electromagnetic lenses are themselves distorted by unavoidable metal imperfections and winding irregularities.

(2) Spherical abberation.

(3) High voltages, although stable may cause electrons to speed through even the most dense part of the specimen. Thus practical specimens must be about 200A° thick to provide enough contrast for photographic purposes.

(4) Photomicrographs can resolve details only 1/10 the thickness of the specimen or 1/10 $\times$ 200 = 20A°. In exceptional cases, objects 6-8A° have been resolved. This is tantalizingly close to the 2-3A° dimensions of atoms; for instance, those atoms making up the D.N.A. molecule.

Promising New Developments

Recently Dr. A. Wilska, a Finnish scientist now working at the University of Arizona, has attracted attention because of two major improvements he has made in the electron microscope which promise to extend the resolving into this vital area.

Electrons accelerated by a lower voltage are, naturally, stopped by thinner sections. This enables smaller particles to be seen and greater contrast to be obtained. However, lower voltages are less stable and more sensitive to lens imperfections, electrostatic charges and stray magnetic fields.

Dr. Wilska perfected a low voltage electron microscope by introducing two main changes:

(1) Cone shaped lenses were used instead of rectangular lenses. This enabled the beam to "see" less of the lens as it passed through and in this way be less affected by its imperfections. This improved contrast yet spherical aberration still destroyed the final image.

(2) Spherical aberration is caused by electrons passing through different parts of the lens coming into focus in different planes. To overcome this, Dr. Wilska blocked the centre of the lens and thus allowed only a "ring" of electrons at the same relative position in the lens pass through and because of their constant relative positions come into focus in the same plane.

A working model employing these two corrections is now under construction and within a year should provide the better resolution required to see atoms.

Other Approaches:

Since $\pi = h/m\,v$, if m is increased with h and v constant, then π will decrease. Therefore, if heavier particles could be used, a greater resolving power could be obtained. A team of French scientists have applied these principles and built a microscope using protons instead of electrons. However, technical problems remain to be solved to provide maximum resolving powers.

Emission microscopes, previously by-passed for the transmission microscope, have again raised some interest. Since electrons are so light and easily affected by stray magnetic fields, Dr. Müller, now of Pennsylvania State University, developed a microscope using heavier particles; i.e., Ions.

The ion microscope operates on much the same basis as the electron-emission microscope. However, a small amount of helium is introduced into the evacuated chamber and floats near a needle anode. Here the high voltage tears an electron from the atom and leaves it a positive ion which is violently repelled from the needle towards a screen. The pattern of the ions striking the screen is a faithful reproduction of the atomic structure of the end of the needle.

With this instrument, Dr. Müller has succeeded in obtaining magnifications up to 10,000,000 with resolutions of about 3A°. This instrument has, however, a serious drawback in that only metals with melting points higher than 1400°C can be used since metals with lower melting points vaporize when subjected to the high voltage necessary to ionize the helium atoms. This instrument has nevertheless opened a great new door for metallurgists.

Another instrument, the ultraviolet light microscope, has been improved by two researchers at the University of Texas. These men have changed the microscope to what they call a "Flying Spot U.V. Microscope".

A spot which is generated on the face of an ultraviolet cathode ray tube is swept in a raster through an ultraviolet microscope onto the specimen under study. This spot sweeps the specimen in the same way a T.V. camera sweeps a scene before it. Under the specimen a photomultiplier collects the light which varies in intensity inversally as the density of the specimen being scanned varies. This fluctuating signal modulates a beam of a T.V. picture tube which sweeps synchronously with the U.V. Spot. The specimen now is undamaged by the U.V. light because the spot moves so rapidly across it.

These instruments, although they have opened and are opening many new doors, are still only providing answers to a few of the many unsolved mysteries of nature.

D. J. Shepley

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Abstract:

Kartagener's Syndrome: C. B. Schoemperlin, et al. The American Review of Respiratory Diseases, *88,* No. 5, Nov. 1963, p. 698.

This Syndrome, originally described in 1933, consists of the triad of situs inversus, bronchiectasis and sinusitis. The latter two occur more often in those with situs inversus. The authors present the case history of an eight-year-old boy who had symptoms since the fifth day of his life. Although this case conformed to the description of Kartagener, the authors point out that variations are not truly Kartagener's Syndrome and it is, therefore, even rarer than commonly held.

Psychiatry in the U.S.S.R.

by Bernard Raxlen

Psychiatry, more than any other branch of medicine is influenced by the cultural environment which surrounds it. And this is natural of course, because psychiatric illness is inseparable from the matrix of values, beliefs, and codifications of reality that comprise a social system. Thus the locus of psychiatry is not narrowed down to a specific individual, but rather it extends into the world of human relationships and ideas that such relationships bring forth[1]. Mechanisms which are evolved unconsciously by the mentally ill are not closed systems within the biological walls of a particular individual. They are in fact commentaries about a certain social process and its validity for the individual. However, as much as mental illness is a reflection of a cultural bias, so also is the way in which the particular culture reacts to the individual who is in need of psychiatric care. The way in which mental and emotional deviates are treated can paint for the interested observer, a remarkably revealing picture of the social, economic, and philosophieal values of the society. Thus by studying the type of psychiatry practised in the USSR, and investigating all its ramifications one can come to some very definite conclusions about the Soviet system as a whole, and its relation to the individual.

Brief Historical Perspective.

The death of Stalin in 1953 marked the end of a definite period in the Soviet Union. Centralized leadership with complete and sweeping dictatorial power, plus strict censorship was characteristic of this period. The Stalin period was also a time in which contact with the outside world was much restricted. The present Krushchev era coincides with a marked improvement in living standards and a corresponding relaxation of many of the former restraints. It was during Stalin's time that Soviet psychiatry, even more than any other branch of medicine, preserved its ideological and national isolation, assailed the character of Western psychiatry and developed its own traditional Russian and Marxist methods. There was a striet point of view within a strict hierarchical administrative structure. This was combined with a naive philosophical materialism which led to an almost total eclipse of psychology and psychotherapy. Instead there was a too strong emphasis placed on the classical Pavlovian approach with the subsequent neglect of all other modes of psychiatry.

Today, ten years later, there has been a "thaw"[2] in Soviet psychiatry. Although it has not abandoned any of its principle positions, it has beeome less dogmatic. It is more conscious of its ties to foreign science and is beginning to show greater variety within itself. More specifically, the recent period is characterized by a greater interest in psychology, personality and psychotherapy. There is also a belated but nevertheless lively interest in psychopharmacology and an increasing interest in biochemistry. The supporting discipline of neurophysiology is also interested in all aspects of modern technology, particularly cybernctics. Finally, there is a strong interest among soviet psychiatrists in reciprocal communication, interchange of personnel, and even in joint research.

I ORGANIZATION OF PSYCHIATRIC CARE

a) *General Organization*

The nature of the Soviet psychiatric service is an integral part of the organization of their society. One of the important features of the socialist state is the fact that regardless of its severity or duration, medical care is not only free, but also includes a large part of the individual's usual salary while he is ill. Therefore, since all levels of the population are guaranteed psychiatric care, an effective system of service must be devised to meet the needs of over 200,000,000 people. A quick look at comparative statistics shows the following: that in the Soviet Union there are roughly 150,000 beds for psychiatric patients while in the United States there are 770,000 beds[3]. The question which immediately springs to mind is this: are there less mentally ill in the Soviet Union than the U.S.A.? — and if not, how are the remaining 550,000 being cared for in a manner that does not neeessitate hospitalization[1]. In regards to the first question, most competent Soviet authorities state that the incidence of psychoses does not differ materially from that in other countries. The estimated rate of psychoses is between 3 and 7 per 1000. This corresponds closely to the rate in the U.S.A. How then are the vast majority of patients cared for? Firstly, besides the 150,000 beds under the Ministry of Health, there are an additional 100,000 beds under sueh diverse organizations as Ministry of Social Affairs (oligophrenics, seniles, epileptics), Ministries of the Interior, and finally an additional 20,000 patients are maintained in their own homes under the supervision of

mental hospitals. Still this is only about one-third the number of beds as compared to the U.S.A. The answer to the problem must lie elsewhere. The solution is found in the Soviet medical system known as 'dispensarization'.

Soviet medicine can be divided into three major branches; 1) child medicine, 2) adult medicine, 3) public health medicine. There are specialists in psychiatry in all these three fields. There is a regular screening of the population (dispensarization) either at the place of work, at the polyclinics, or even at home if necessary. Psychiatric illnesses are diagnosed at this time and the patients are referred for appropriate care. Therefore in contrast to the USA, medical care is centered around the dispensaries rather than either private practise or the hospitals. A psychiatric dispensary is quite different from the other medical dispensaries because besides direct psychiatric treatment there is also a work therapy programme carried on within the confines of the institution. The psychiatric hospitals are reserved almost entirely for the treatment of *acute* patients. Most hospitalization is for an extremely brief period of time by American standards with early discharge and follow up observation at the dispensaries. In other words the turnover of patients in Soviet psychiatric hospitals is much greater than in the USA. And herein lies the answer as to how the system makes do with far fewer hospital beds then the USA, but nevertheless treats and looks after almost as many patients. The ratio of admissions to beds is 3:1 in the Soviet Union. In the USA it is 1:3. This represents a ninefold difference. Almost all patients who have spent some time in the psychiatric hospitals are referred back to the dispensaries and thus there is a constant flow of cases from the hospital to the day care units. There is virtually no static population. Whereas in the USA chronic long stay patients are the norm and the hospital population tends to be stagnant, in the Soviet Union as has been shown the opposite holds true.

One of the great advantages of the above system is the fact that the psychiatrist-patient ratio in mental hospitals in the Soviet Union is between eight and nine times greater than in the United States. In the USA the ratio is 1 psychiatrist to each 200 mental patients; in the Soviet Union the average ratio is 1:25. One must add however, that approximately one half of the psychiatrists in the United States are engaged in intensive psychotherapy and this limits the number of patients for whom they may care. This is far less frequent in the USSR. Thus viewing total statistics once again it is found that there are between 5000 and 6000 psychiatrists and between 10,000 and 12,000 neuropathologists. The psychiatrists deal entirely with the psychotics. The neuropathologists, aside from a small number of neurological conditions, treat the neurotic patients; these patients in some cities such as Leningrad have their own special hospital. Besides the above mentioned types of care (dispensaries, psychiatric hospitals for the psychotic patient, neuropathological hospitals for the neurotic patient) there are also other special hospitals. Again taking Leningrad as an example, there is the Kashenko and Balinski Hospital for semi-chronic patients (1600 beds), the Deteskaya Hospital for children (200 beds), hospital for alcoholics (100 beds) and finally the Bechterev Hospital, a research institute with 400 beds[6]. The long term chronic psychotic patients are maintained in work villages such as Nicolska outside the city limits. The inmates are employed in industry and agriculture.

Another excellent feature of Soviet psychiatric organization is the fact that a sizeable number of patients are handled at home. They are cared for by their own families under the supervision of the hospital. When an individual becomes mentally ill he is able to receive a disability pension for as long as he is unable to work. The family receives separate and direct compensation if the patient's illness causes hardship. This fund plus the patient's own disability pension make it economically quite attractive for a family to look after a patient. This system is less expensive for the state than maintaining the patient in the hospital. In most cases it is more stabilizing for the family and is therapeutically more beneficial to the patient.

A rather unique aspect of the psychiatric services offered in the major cities is the "quick psychiatric emergency" system. Teams of full time, well qualified psychiatrists and nurses are stationed in various areas in the city and are attached to the general medical emergency centres. In Leningrad there are eight such teams so located that they can be at the scene of an emergency within minutes, whether it be an attempted suicide, a disturbed psychotic episode, or some other type of acute psychiatric emergency.

For all milder chronic conditions, including psychiatric ones, there are the *sanatoria* located in pleasant surroundings, usually near beaches, lakes, or mountains, to which patients go for rest, relaxation, and enjoyment.

b) *Physical Facilities within the Hospitals*:

By USA standards the hospitals are greatly overcrowded. A number of institutions destroyed by the war have not yet been rebuilt. In many places the beds are 6 inches narrower than the ones used in

the USA and at times only one foot apart. The Third Psychiatric hospital in Leningrad is fairly typical. The hospital consists of 19 separate buildings with 90-100 patients in each building. There is a large club where all the patients are able to go in bad weather. Because of overcrowding, patients are cared for out-of-doors as much as possible. In rainy weather it is not unusual for the patients of an entire cottage group to be sitting on the porch along with their physicians. The original buildings dating from 1870 are still in use.

The Neuropsychiatric Clinic No. 1 in Moscow known as the Kashchenko hospital may serve as another example. This hospital is one of the eight Moscow district hospitals. Built in 1894 it now has a staff of 2,210 for a patient load of 2,400 including 168 doctors and 600 nurses. A staff-patient ratio of almost 1:1. Dr. Joseph Wortis, who conducted an extensive psychiatric study tour of the USSR described the hospital in this way:[4]

"it was a pleasure to look through this well kept hospital. Though the structure was by no means new, it was pleasant and extremely clean. The rooms were home-like, with plentiful use of potted plants and ferns. The patients were obviously made to feel welcome, were accorded kindly and given most adequate nursing attention. From all that I could see excellent medical care was the rule. The disturbed ward was relatively quiet, the sedated patients seemed to be sleeping easily in bed, and other patients were quite well controlled. In the convalescent wards the patients were beaming, and in the outside gardens a number of them were seated or strolling."

c) *Medical Education and Specialty Training*:

An applicant for examination to the American Board of Psychiatry must spend approximately 25 years plus 2 years clinical practise before he is considered a candidate. In the USSR there is a combined 10 year elementary and high school course, followed by six years at a medical institute, the last one of which is spent in specialization. Thus a total of 16 years is sufficient to qualify as a specialist. The medical schools have not been connected with the universities since 1929. The graduate of a medical teaching institute receives a physician's certificate, not a doctor's degree from a university. In the fifth year of medical school there are 30 hours of lectures in psychiatry and 30 hours of demonstration. One of the biggest problems that a Soviet physician faces after he graduates is the lack of basic practical and clinical experience.

The salary of the average physician is about 1500 roubles a month, as contrasted with the average for the general population of 1300-1400. Since the physician does not occupy the relatively high socio-economic status that he does in the USA (the select groups being the artists and scientists) he is not under obligation to achieve the symbols of status. Bonuses are paid to a specialist on the basis of whether his work is dangerous. A surgeon whose specialty is regarded as safe receives no more than the general practitioner. But the psychiatrist who works with patients who are potentially dangerous receives a bonus of 15-30%. In addition he is permitted to retire in 20 years instead of the usual 30 years. His annual paid vacation is 30 working days, instead of the 18-24 working days allowed the ordinary physician.

II TREATMENT OF THE PSYCHIATRIC PATIENT IN THE USSR

The above facts regarding the superstructure and the organization of psychiatric services point out quite clearly that the USSR has built an impressive architectural framework in which to treat mental illness. But this is only the framework. What can be said about the actual treatment and the effectiveness of its results? One can safely say that with the 'thaw' in Soviet psychiatry in spite of a rather strict hierarchy of organization there is scope to manoveure. Both differences and discontents find expression. Therefore treatment is not strictly uniform but on the contrary shows variation depending upon the individual bias of the physican or the institute with which the patient is affiliated. There are however certain common denominators which underly all Soviet treatment and they might be summarized as follows.

1. *Work Therapy*: Using the example of the Bechterev hospital in Leningrad one learns that every patient in the hospital is required to do some type of work therapy. This is also a prominant feature of the psychiatric dispensaries. The work therapy shops constitute complete industrial units. In the aforementioned hospital there are six full scale looms on which material for snow suits are woven. There are also shops for box-making and fountain pen manufacturing. Not only is there on the job training, but patients are paid for the work that they perform. The learning of the new skills plus the payment for work performed provides the patient with a feeling of worth and self respect. Work therapy is employed as a method of treatment for psychotic, neurotic, alcoholic, and personality disorders.

2. *Sleep Therapy*: Sleep therapy, having its roots in Pavlovian theory, is a popular form of treatment in the USSR. Both prolonged and interrupted sleep are in-

duced by electro-methods, sodium amytal, alcohol, or glucose. Prolonged sleep, as claimed by Professor Popov at the Korsakov Institute of Psychiatry, gives excellent results in neuroses and neurasthenia. Sleep treatment is also helpful in obsessive-compulsive states. Transient obsessive states which occur in otherwise normal people are said to have a 90% cure rate. Good results have been obtained in reactive depression but the results are not good in endogenous depression. However the value of sleep treatment has been questioned by Professor Miasishchev of the Bekhterev Neuropsychiatric Institute of Leningrad. He states that the use of sleep treatment has been overstressed in recent years in the USSR. Though Pavlov recognized its importance, Soviet psychiatry exaggerated its claims. Drug induced sleep was not equivalent to natural sleep and electro-sleep was obscure as regards its mechanism.

3. *Schizophrenia*: Turning to some of the more specific disorders such as *schizophrenia* (Figures for 1954 showed that 37% of all patients in the Soviet mental hospitals were diagnosed as schizophrenics vs. 49% in the U.S.A.), treatment in spite of research and theory is largely empirical. The most common and important treatment for schizophrenia is hypoglycemic insulin treatment. Also Insulin plus sulphur as a fever producing agent for chronic cases is highly regarded. Chlorpromazine is used when anxiety or other affective components seem prominent. In Kiev, special interest has been shown to the 'hypoxic' theory of schizophrenia. Patients are conditioned to either high altitudes or low pressure chambers. One control study showed that schizophrenic patients transferred to high altitudes (4000 meters) underwent striking remissions from chronic catatonic states after a month's exposure. The other group of patients in the study were sent to a lovely scenic spot at sea level. They failed to respond. This unusual tolerance to low O_2 pressures as manifested by schizophrenics may yet prove to be a fruitful line of enquiry into the nature of the disorder. Shock-therapy, a common mode of treatment in the USA, is coming under increasing criticism in the USSR and is used sparingly. The small haemorrhages that it produces, the memory difficulties, the delay in the establishment of conditioned reflexes after treatment, have all tended to discredit its use. It is definitely contra-indicated in neuroses and is employed as a last resort in chronic schizophrenia and resistant cases of depression.

4. *Alcoholics*: Alcoholics in the USSR represent almost 10% of all patients admitted to mental hospitals (as compared to 3% in the USA). The emphasis in treatment is placed on out-patient care, but hospitalization is resorted to if the patient is acutely excited or has developed an alcoholic psychosis. Chronic alcoholics are remanded to chronic colonies where they will remain for at least six or seven months under a work programme. For example a thirty year old heavy drinker with recurrent difficulties would be punished by the law if he actually created some public disturbance. Ordinarily he would be admitted to some O.P.D. facility or hospital, or to a 'sobering up station'. Here he would be bathed, given a stimulating shower, and sedation if necessary. He would be sent home the next day after paying for board and service. His factory director would be informed and he would be required to report back daily to the dispensary for approximately one week. He would also probably be contacted by his youth organization, trade union, or by his local physician. He might even have a delegation of fellow workers come to his home.

5. *Sanatoria*: The Sanatoria of the USSR do much to dispel the usual image of Soviet life as a tedious and monotonous round of daily chores without relaxation or concern for individual comforts. A great majority of the patients at the Sanatoria appear to be in perfectly good health. About 25% of the patients have some neurotic disorder. Figures estimate that the number of beds in Sanatoria and rest homes number over 400,000. Treatment is essentially the same in all sanatoria. This consists of relaxation, sun-bathing, carbonic acid baths, radium baths, and even in some places hydrogen sulphide baths. Treatments for insomnia, high blood pressure and asthma includes 'negatively ionized gas'. Patients sit around a table and the gas is blown in their direction. Mud treatment is used to ease increased muscle tonus, for stomach and liver diseases and also nervous disorders. Even electromagnetic field treatment is used in some Sanatoria. The patient is placed in an electromagnetic field for a 10 minute period if he is suffering from high blood pressure. Its results are very questionable. In essence the sanatoria appeared to comprise little more than vacation spots. Rest and relaxation are certainly medicinal but serious treatment does not seem to be the purpose of these institutions. There are, however, 15,000 physicians and 35,000 paramedical personnel engaged full-time in the Sanatoria. This appears to be an enormous expenditure of manpower by Western Standards.

6. *Rational Psychotherapy*: Rational psychotherapy is based on Pavlovian doctrines. There is a strong antagonism to Freudian psychoanalysis and his theory of the unconscious. In a paper delivered to the World Psychiatric Congress in Montreal in 1961, F. V. Bassin in discussing Freudian techniques stated, "Our approach emphasizes the primary importance of central nervous factors because of the important role of the environment in determining functional states of the organism. Hence

we emphasize the environmental, social and biological factors in determining and treating clinical syndromes, rather than hypothetical, internal, self destructive tendencies of the organism, the existence of which is largely postulated and not demonstrated in psychoanalytic literature." Thus the Pavlovian orientation prevails that 1) man is a product of his environment, 2) instincts are repressed by social forces, 3) the primary method of treatment must be re-education plus physiological or pharmacological treatment of the nerves themselves. The actual techniques employed by psychotherapists consist of producing material from the patient, with particular emphasis on early childhood, on work, and on environment, together with his reaction to them. The psychiatrist must make clear to the patient the way in which the environment has worked upon him.

III THEORETICAL CONCEPTS

In the USSR any study of normal or abnormal behaviour has been conditioned almost exclusively by Pavlovian theory. Pavlov has been to psychiatry in Russia what Marx has been to political thought and economic theory. One of the major reasons for the great emphasis on Pavlovian theory was the fact that it appeared to give scientific validity to the Marxian concept of man. As has been said earlier, psychiatric illness is inseparable from the values, beliefs, and codifications of reality that comprise a social system. How then does Marx view man and the social order and in what way does Pavlov substantiate this view?

(a) *Marx*: Marx believed that man was an object in nature, and nature's laws discovered by science applied to man just as they did to other material objects. Like the materialists he denied the existence of an immaterial soul and spiritual substances of any type, and regarded the concept of God as a basic falsehood. He maintained that natural sciences alone could provide true solutions to all questions of fact, among them the laws governing the evolution of individuals and societies. In Marx's view all sensation or perception is an interaction between subject and object; the bare object apart from the activity of the percipient is only raw material which is transformed in the process of becoming known. Knowledge in the old sense of passive contemplation is an unreal abstraction; the process that really takes place is one of *"handling things"*. "The truth, the reality and power, of thought must be demonstrated in practise. Philosophers have only *interpreted* the world in various ways, but the real task is to *alter* it[5]." Thus according to Marx, we only notice things as part of a process of acting with reference to them; any theory which leaves out action is a misleading abstraction.

Marx also speaks of the concept of *alienation*. This is a phenomenon which occurs when something created to sustain human needs acquires an institutional life of its own, an independent existence, and presents itself as some inexorable law of nature or all-powerful God. For Marx, the moral and religious values of what he calls the 'capitalist' world, are precisely such forms of alienation. Men are not only in conflict with uncontrolled nature, but they are also at the mercy of the monsters of their own making — institutions, habits, & beliefs, whose origins are forgotten and whose functions are no longer understood. The importance of Marxist theory as a system of thought lies not in its validity or its failings. What is important is the fact that the Marxian concept of man which includes the origin of his institutions, his ideas and his morality, are accepted as *reality* in the USSR. The Soviet citizen lives by these maxims enunciated by Marxist philosophy. Any man lives by those propositions whose validity is a function of his belief in them. The stronger the belief, the more valid certain pronouncements about society and the world around it will seem. The Pavlovian doctrines of human behaviour seemed to give a scientific underpinning to the Marxian universe.

(b) *Pavlov*: Pavlov (1849-1936), became famous in scientific circles for his work on classical conditioning. Using dogs as experimental animals in a strictly controlled environment he established the existence of the conditioned reflex. To study it he devised an apparatus (as every abortive student of psychology knows) for measuring the flow of saliva. He then presented food sights, sounds and other stimuli in such a way that he could see how these stimuli gradually came to affect the flow of saliva. Pavlov called the salivary response to food the *unconditioned response*, because it occurred without learning and he called the food the *unconditioned stimulus* for the same reason. He then paired a bell with the food; after several times he removed the food and lo and behold the dog still salivated to the tinkle of the bell. Thus *conditioning* had occurred. The bell was the *conditioned stimulus* and the saliva had become the *conditioned response*. Then Pavlov turned the dinner table on the poor dog so to speak. He sounded the bell, the dog salivated in anticipation, but no food was given afterwards. After a few more trials of this the dog gave up and his salivary response did the same. This process which was the reverse of conditioning Pavlov called *extinction*. And Pavlov wisely concluded that some *reinforcement* (i.e. food) must be paired with the conditioning stimulus. Thus a fundamental learning principle was devised from this experiment, namely the principle of reinforcement[7]. These simple but ingenious set of experiments became the basis for all

his later investigations and eventually led to his theoret-complete unison with the conditions of existence. Pavlov demonstrated on the basis of anatomically fixed nervous paths, that reflex connections of animal organisms bear an adaptive character. These reflexes emerge and vanish during the individual development of the organism in complete unison with the conditions of existence, Pavlov showed that these reflexes are of a coupling nature, and that they are also temporary, because they disappear under definite conditions. He regarded the conditioned or acquired reflexes as a special *organ* of the animal make-up especially adapted to effect a more and more perfect balance between the animal and the environment. The conditioned reflex became an immediate reaction to the diverse combinations and fluctuations of phenomena in the surrounding world.

On the basis of almost thirty years work on conditioned reflexes, Pavlov elaborated the *typology* of the higher nervous activity in dogs, and found that this typology coincided with the four human temperments described by Hippocrates. In Pavlov's own words here is a brief formulation of his work[8].

> "The cerebral hemispheres are continually receiving countless stimuli both from the external world and the internal medium of the organism itself . . . Countless and varied positive processes enter the cortex along the conductor paths and in the cortex they are joined by inhibitory processes. All these meet, collide, must come together and be systematized . . . This is a nervous task of considerable difficulty, the degree of which depends upon the stereotype and on the individuality of the animal. There are nervous tasks which require from animals of the strong nervous type painful effort. Other animals react to any simple change in the system of conditioned reflexes, such as the introduction of a new stimulus, or even a certain transposition of the old stimuli, by the complete loss of the conditioned reflex activity. Some animals can retain the proper system only if there are recesses in the experiments. And finally some animals show regular work under a very simplified system of reflexes.
>
> Our entire work gradually allowed us to establish various types of nervous systems in animals. Our systematization of type coincides with the ancient classification of the so called temperaments. There is a type with a strong excitatory process, but a relatively weak inhibitory process. Animals belonging to this type are aggressive and unrestrained. They are the *choleric* type. Next comes the type of strong and at the same time equilibrated animals, in which both processes are of equal strength. This is an easily disciplined and highly practical type which is met in two variations — quiet *sedate* animals and active lively ones. They are called respectively *phlegmatic* and *sanguine*. Finally there is the weak inhibitable type, in which both processes are weak. They are highly susceptible to external inhibition, are cowardly and fussy. These are termed *melancholic*.
>
> We also know which type of animals can easily be turned into neurotics, we know how to achieve this and what kind of disorder will set in. The choleric type and the melancholic type are the best objects for the elaboration of experimental neuroses. We already have and we can even produce certain symptoms of psychotics: stereotypy, negativism and circularity.

Pavlov's theoretical generalizations disclosing the nature of the higher nervous activity culminated in his concept of the first and second signalling systems. The latter was regarded by him as inherent only in the human brain. He stated, that when the devloping animal reached the stage of man an extremely important addition was made to the mechanisms of the nervous activity. Man possesses, as do the lower animals, impressions, sensations, and notions of the world around, both the natural and the social. These come by way of the special senses. This is known as the *first system of signals* of reality. However, man has devised speech which constitutes a *second signal system* — in other words, a signal of the first signals. Thus on the one hand speech has removed us from reality, and on the other hand it is that which has made us human. Pavlov believed that the laws governing the first signalling system also governed that of the second. With these concepts as a starting point, Pavlov then stated that there are large numbers of people, who operate almost exclusively with words and fail to base themselves on reality. They are ready to draw from these words every possible conclusion and all knowledge. There is another type of individual who anchors himself in reality, reacting to the world on an empirical basis. Thus he divides human beings into artistic, thinking and intermediate types. As stated previously in his initial typology, the melancholic type (weak inhibitable type) was most susceptible to neuroses. Neurasthenia (a term no longer used today) was according to Pavlov a combination of the feeble general type combined with the artistic type. A hysterical person was the product of the feeble-general type and intermediate type. In the hysterical person, there was weakness of the second signalling system. Thus the chaotic character of the activity of the first signalling system and the emotional fund in the form of pathological fantasies resulted in profound destruction of nervous equilibrium (i.e. paralyses, contractures, fits or lethargy). In the psychasthenic patient, (a combination of the feeble-general type and the thinking type) it is the first signalling system which is affected and the emotional fund is deprived. Hence, the absence of a sense of reality, continual feeling of inferiority with life, with constant fruitless and perverted cogitation in the form of obsessions and phobias. Pavlov also expands his theory to include the other psychotic states, such as the manic-depressive psychoses and schizophrenia. The theory behind these illnesses will not be elaborated here.

This article will not attempt a critique of Marx or Pavlov. Both men have made outstanding contributions in their respective fields and their influence not only on Soviet life, but outside the USSR has been enormous.

However up until the death of Stalin, the work of Pavlov rather than being one approach to the problem of human behaviour both normal and abnormal became the only approach. Rather than a scientific postulate, Pavlovian theories became dogmas. They assumed ironically enough, the aspect of *alienation* of which Marx so bitterly speaks. In other words they became institutionalized truths in order to give scientific validity to the Marxian concept of man.

To-day, as has been previously mentioned, Pavlov is still revered in the USSR, but new lines of enquiry are being investigated in areas where Pavlovian theory has shown weaknesses.

IV SUMMARY AND CONCLUSIONS

From the above discussion of psychiatry in the USSR it is obvious that there are areas in which the approach to the problem of mental illness is superior to our own. These are summarized by Dr. Kline in his revealing study as follows:

1. The stress is placed on ambulatory dispensary service. Patients are cared for less expensively, the number of long stay chronic patients is greatly reduced, and there is no extensive break with either family or community. It is estimated that without this system at least 50% more hospital beds would be needed.

2. There are regular and large-scale examinations of the population; during these examinations any psychiatric illness is referred to the appropriate specialist. Hence the patient is not lost between the time of referral and the arrival of the psychiatrist.

3. Disability payments continue indefinitely, and both dispensary costs and hospitalization are completely free. Thus there is no financial reason for a patient to reject treatment.

4. The guarantee of employment after the patient's convalescence removes the apprehension that mental illness might prejudice his chances for future work. Work therapy with on the job training enables the patient to maintain their moral and financial self-respect despite their illness.

5. The provision which allows hospitals to pay families for the care of the patient at home encourages the family to assume responsibility and care of the individual. This results in a 50% saving to the hospitals and is of therapeutic benefit to the patient.

6. Psychiatric emergency teams are located in strategic areas throughout the major cities, to handle any psychiatric crisis which may arise. This circumvents the need for police or any other semi-skilled or unskilled intervention.

7. There are a greater number of psychiatrists in the USSR, approximately 50% more per population than the USA. Three to four times as many physicians graduate each year. Hence the ratio of trained staff to patient is much lower than in the USA. In some hospitals it is almost on a 1:4 basis. Normally however, the ratio is 1:25 as compared with 1:200 in the USA.

8. The hospital atmospheres almost always reflect kindness, humanity and an orientation to the needs of the patient. The patients, both adults and children alike — looked secure in the hospital setting, and as Wortis states during his tour "I did not see any of the forlorn neglected creatures so often found in our own public hospitals."

9. Neurophysiological research is on a technically high level, scientifically sophisticated, and sooner or later destined to produce excellent results.

10. Research is rapidly increasing in the USSR. The research scientist enjoys high economic and social prestige. Research is the primary responsibility of researchers and teaching is secondary.

Dr. Wortis on his psychiatric study tour was by in large very favourably impressed with the organization and spirit of the whole psychiatric service in the USSR. The advantages have been listed above. His general critique of the Soviet system amounted to the following observations.

1. In spite of the broad and thorough coverage of psychiatric and other health services there was a certain lack of finish and efficiency to the services I could observe.

2. Buildings were often dilapidated, though clean. The treatment wards often seemed crowded and unorganized. Hospital tempo was slow, with manpower lavish and wasted.

3. In spite of theory and research the treatment methods, like ours, were too often largely empirical. Pavlovian formulae were repeated with stereotyped montony and other approaches seemed secondary in comparison.

4. Minor neuroses and psychosomatic mechanisms seemed to be neglected, and psychotherapy as we know it, was non-existent.

5. There was more separation of research, teaching, and clinical service than in the USA. More research should be done in clinical settings, and more clinicians

should be doing research. Psychiatric research was too uniformly Pavlovian. Population, epidemiological studies, more large scale and systematic therapeutic studies, chemical, endocrine and genetic directions should be followed.

Conclusion:

Obviously within any system or organization there is room for considerable improvement and alteration. Nothing remains static, and certainly within the field of psychiatry and psychiatric research the horizons are unlimited. Under a free enterprise system such as in the USA or Canada, there exists great diversity of thought, organization and treatment. This climate allows for spontaniety of enquiry, personal freedom, and immunization from scientific dogma. Hence new methods, new theories, and new areas of endeavour are constantly being explored and investigated. Other disciplines of thought in such areas as biochemistry, electronics, genetics, anthropology, and psychology to name but a few are incorporated into psychiatric research and thinking. And this is as it should be because the science of human behaviour both normal and abnormal overlaps into so many other specializations. History is a great educator. And the history of Western thought has proven time and time again, that where there is the greatest freedom for intellectual curiosity, there will always arise those individual discoveries of unexpected brilliance. A democratic society is a society which should allow the widest latitude for individuality and variability without the imposition of stifling political or rigid scientific dogmas. This gift should not turn into complacency or the solopsistic view that what happens to us is important, but what happens to those around us is not really of much concern. For all our talk about the great free enterprise system as opposed to the Communist State, it appears that in regards to psychiatric care and the treatment of the individual patient we can learn a great deal from the Soviet approach. The relation of the psychiatric services in the USSR to the patient's family, his place of employment, and to the community at large is an enlightened and effective adjunct to his personal treatment. Anxieties which might be faced by the Soviet man due to loss of job, loss of self respect, or financial disaster are eliminated in the Soviet system. Perhaps the strongest impression that one may glean from a report of this type, is the fact that mental illness in the Soviet Union is regarded as just that. Psychiatric patients are treated with the respect accorded to any other disease entity. Here, on the contrary, the stigma of mental illness is still strongly imprinted on any unfortunate individual who should fall victim to this blight. What is the value of intensive psychotherapy, espensive pharmacotherapy and all the other methods of treatment, if the individual when he leaves the confines of the psychiatrist's office, or the walls of a mental institution, is thrown into a hostile and unsympathetic community? In North America this situation is the rule, not the exception. In both systems there are strengths and weaknesses. The USSR is rapidly liberalizing its thinking and critically examining all that Western technology and theory has to offer. They are adding this to an already solid superstructure of scientific investigation and practical organization. The question is, what are we learning from the USSR?

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Medical Horizons: Our Man in Athens

Last summer I was fortunate enough to spend one month at a surgical hospital in Athens, Greece. This hospital, while old and lacking some of the facilities found in Canada, offered a level of patient care of which the staff was justifiably proud. On the wards I encountered many familiar conditions, but others (such as hydatid disease) assumed greater clinical importance than in Canada. Echinococcal cysts are not uncommon in Greece, and their removal from the liver is a frequent operation; cysts in the lung, however, prove more difficult to treat and I observed the protracted period of pulmonary suction necessary to treat this condition. Also on the wards were severely burned children undergoing a series of transplant operations, and here even the changing of dressings was an exquisitely painful procedure. Yet these children, and many other patients, displayed a keen interest in my presence and, despite my rudimentary command of the Greek language, endeavoured to communicate and joke with me. It was in such an atmosphere that I was introduced into the basics of Greek medical care.

Monday, Wednesday and Friday were the days when surgery was performed. I was encouraged to view as many operations as possible — appendectomies, tumour excisions, amputations, pilonidal sinus drainages, gastrectomies — some were interesting; some were incomprehensible; some were a revelation! Despite their busy schedules, the surgeons explained the procedures followed, and often in these explanations their English and my knowledge were put to a severe test.

During my stay in Greece I attended an International Congress for the study of diseases of the colon and rectum. This conference was attended by surgeons, pathologists, gynecologists, and researchers from Japan, United States, France, Hungary, Italy, Germany, Holland, Jugoslavia, Rumania, Sweden, Britain, Spain, and Bulgaria. Because of the disparate backgrounds of the participants, simultaneous translators were necessary to make the films, panel discussions, and papers presented understandable to all. Most enjoyable, I felt, were the panel discussions, which in a far reaching and sometimes controversial manner covered such topics as anal carcinoma, rectal prolapse and hemorrhoids.

In Athens emergency services are provided by various hospitals in rotation, so that not all are on call any one day. I can recall one night spent watching people brought in bleeding, battered and broken; their injuries were assessed and treatments immediately instituted. In some cases only elementary first aid was required; in others a bed on which to sleep it off; in still others major surgery. On such nights the hospital was like an old machine, well oiled and running smoothly.

Yet, in retrospect, Athens was much more than the sum of the foregoing. It is a city of peoples proud of their past, yet living heartily in the present. Remnants of the past are everywhere, the most impressive being the Parthenon, which at night is illuminated and dominates the city. It is strange how these broken columns on the crest of a hill embody both ethereal beauty and rugged, almost stubborn immutability. At the foot of the Acropolis is Plaka, the old quarter of Athens, where homage is paid nightly to Dionysus, amidst song and dance and lively revelry.

During the hot summer days many people forsake the city for the pearly beaches of Glyfadha and Vouliagmeni, where they battle the breakers or simply luxuriate in the Aegean Sea. As evening falls the crowds disperse, and later meet in the seaside ports where food and entertainment are provided. I remember well one evening spent in the port of Piraeus, where the American fleet was anchored, the ships' lights casting a glow over the entire harbour. The occasion was a festive one, and I was introduced by friends from the hospital to Greek food — octopus, squid, meat wrapped in wine leaves and the thick Attic wine.

From Athens many points on the mainland are easily accessible, and there I proceeded to visit. Many combined historical and mythological interests — Delphi, Olympia, Mycenae, Corinth, Tyrins, Thebes, Eleusis — and I enjoyed comparing the stark columns and pillars that remain with Homer's description of what once existed and now no longer is. At Epidaurus I visited the centre of the cult of Asclepios, the god of medicine; to this sanctuary were attracted sick people from all corners of the ancient world. Today people flock to the theatre of Epidaurus to view the classical dramas of Aeschylus, Aristophanes and Euripides, I saw the presentation of "Aclestis" and was amazed how unimportant language became; fluidity of movement and sonorousness of speech penetrated the

language barrier, and the tragedy was no longer an academic museum piece, but came alive.

Language and alphabet are not, however, the only differences between Greece and the rest of Europe. Greece is a poor country which still bears the scars of the War and the post war period. Unlike most of Western Europe there is no television, cars are relatively few and the pace of life is slow. These forces and geographical isolation have produced a people that treasures its past, but savours its present. I have seen the Greeks in many guises: as fanatic fans at a soccer match; as volatile and animated antagonists discussing the summer's political crisis; and as warm and hospitable hosts to strangers in their country.

Some day I should like to return.

L. E. Cappe 6T5

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Abstracts

Ann. of Int. Med. 59, No. 5, Pt. 1, Nov. 1963, 605-614. *The Diarrhea of Travelers to Mexico* — Summary of a Five-Year Study: B. H. Kean.

This article investigates the diarrhea which affects up to one-third of North Americans travelling abroad. It has many euphonius names, among them: turista, Montezuma's revenge, Aztec two-step, Casablanca crud and Tourist trots. After an exhaustive study the following points may be made to summarize the disease: the cause is unknown; the cure is unknown; prophylaxis is of little effect (drinking boiled water, avoiding foreign food, etc., is often impractical when travelling abroad). The disease usually lasts 3-4 days with malaise, vomiting, diarrhea and fever and remits spontaneously leaving no ill effects.

The Credo of a Surgeon: C. E. Welch. *Annals of Surgery, 158,* No. 5, Nov. 1963, 740-746.

This article is written in honor of Dr. E. D. Churchill and contains his ideas on the credo of a surgeon. In his words, a surgeon: personally must be courageous, quick in decision and action and, if necessary, ruthless to attain his goal; should not deprecate his own abilities nor those of his profession; must devote himself to the art and practice of surgery; may praise compassion but must recognize its limitations; must hold loyalities that are intense and effective; must not be fettered by the chains of a narrow specialty; must recognize the importance of projection to avoid retrogression; must appreciate the significance of history; must attain scholarship by incisive thoughts based upon precise actions and finally, surgery shall be judged by its results.

Psychiatric Emergencies

by Richard M. Gladstone

Introduction

The student interested in human behaviour may well ask, "What is a psychiatric emergency?" for this phrase is not even found in the index of many of the standard textbooks of psychiatry. This is not because psychiatric emergencies do not exist, but rather because they defy comprehensive and accurate classification. Psychiatric emergencies can occur among individuals and among groups of people; indeed, whole populations may be affected. Such things as nuclear explosions, earthquakes, shipwrecks, tidal waves etc. constitute major threats to the populations involved and produce behaviour patterns that we as physicians should well understand.

In general, psychiatric emergencies occur among individuals when there is a sudden change in the ability to control one's behaviour and carry out the usual personal, vocational, and social activities of daily living. As such, emergencies are not restricted to any single category of psychiatric illness, but can occur in those with psychoneurosis, psychosis, organic states, personality disorders, or even psychosomatic illnesses. At times the patient will come to the doctor on his own, complaining of overwhelming panic or fear; at other times, friends, relatives or the police may direct the patient to you because of violent and aggressive behaviour which may be threatening his life or the lives and property of others. In this article we shall examine and discuss the therapy of the Group and Individual psychiatric emergencies, with special reference to the management of actively hostile patients.

Part 1.

GROUP EMERGENCIES

(a) *Reaction Patterns.*

Several authors point out that during catastrophes such as war, fire, flood and storm, a general regression of human behaviour can occur. Meerloo, who studied the behaviour of soldiers during World War II has described two types of panic behaviour; firstly, a general paralysis of action and emotion, and secondly, temper tantrums.[1] In the former, the individual is in a state of mental paralysis. He has literally "frozen on the spot". He looks apathetic, cannot talk, and can't move. He does not seem to listen or hear what is said and only his frightened eyes seem to be alert. This cataleptic type of reaction is very frightening to those who witness it. In the second type of panic reaction the individual behaves like an angry child. Soldiers may attack their own buddies or shoot at their own troops. Women may begin to shout, scream and cry, and wander about aimlessly, wringing their hands. However, these reaction-types occur in the minority of people. Some will remain cool and collected; others will be stunned or dazed but still effective.

(b) *Management.*

I. *Leadership.* Group emergencies demand that a responsible person quickly assume leadership and control of the situation. He must remain calm and show a paternal, directive and optimistic attitude. During disasters, military or civil officers, doctors, or clergymen can fill this role. Effective leadership is the most successful weapon in combatting mass hysteria. Indeed, chaos results from the failure of good leadership.

II. *Explanation.* Explanation of the situation is essential, for people are always less afraid once the element of unknown has been removed. Bodily responses such as sweating, tachycardia, rapid breathing, giddiness, nausea or even vomiting may occur as part of the "fight or flight" mechanism. Painful vaso-constrictive sensations, and frequency of micturition are also common. These reactions usually soon disappear and explanation of their causes has a beneficial sedative effect.

III. *Evacuation.* The next step is to remove all people from the danger zone as quickly and as orderly as possible. Traffic control is also necessary to prevent convergence of people from outside the disaster area at the disaster site. This convergence by car, rail, telephone etc. presents a major problem because it hampers rescue, medical relief and rehabilitation programmes.

IV. *Medication.* Narcotics and sedatives to the physically uninjured are to be avoided, for it is known that people obsessed with fear may react to sedatives in an unexpected way. Hot drinks, such as coffee, tea and soup and later cigarettes provide the best medicine. They provide oral gratification which in times of general regression is most useful. The "paralyzed" cataleptic can be brought around with sniffs of eau de cologne or ammonia and then offered a cigarette. The experienced psychiatrist can make use of such techniques as first-aid hypnosis, and first-aid catharsis, (in which the patient attempts to relive the frightening experience mentally) and narcoanalysis[2].

V. *Groups.* Disaster leads to dependency feelings. The need to be with others is so strong that social barriers seem to disappear momentarily. Disaster results in a dramatic increase in social solidarity, and an outpouring of love, generosity and altruism. Individuals should be returned to appropriate groups very quickly, especially to family groups. "Talking-out" of experiences should be encouraged, and every able person should be given a definite useful task, no matter how small[3].

VI. *Registry.* It is an extremely important duty of those who assume leadership to compile an official list of survivors as quickly as possible[4]. This is an important method of organizing people, combatting panic, and of maintaining morale. Uncertainty over the fate of loved ones causes great anxiety. More psychological disturbance may occur over concern about relatives than over the danger to oneself. Making a survivor list has many other functions as well. It is reassuring to the bewildered survivor to be recognized as an individual; the mere recording of his name, address and next of kin helps to re-establish in his mind the intactness of his shattered ego.

VI. *Information.* The best way to avoid demoralizing rumors is to establish an accurate and quick information service and to communicate news to all concerned as soon as possible. Negative information is as important as positive information. For example, if no information is available, it is important to make it known that no information has yet been received.

(c) *Presentation of a GROUP emergency.*

During the Andrea Doria disaster, two psychiatrists observed the emotional states of the survivors[5]. They found two distinct reaction phases — first, the initial shock, and then the recovery phase. They remark that during the initial shock the survivors acted as if they had been sedated, as if an anti-panic mechanism had automatically been turned on. The American survivors acted passively and compliantly, displaying psychomotor retardation, blunting of emotions, somnolence and amnesia for date or personal identification. This attitude of helpless dependency is characteristic in group disasters, as was described above. It signifies a state of emotional regression in which people who are normally capable of functioning on a mature adult level become child-like in their feelings of personal inadequacy, and in their tendencies to over-estimate the powers of those offering help and leadership. In their state of "shock", the survivors of the Andrea Doria could be compared to the survivors of the concentration camps who were found to have developed a state of "emotional anaesthesia" as a defence against the dangers and anxieties to which they were constantly exposed. Freud spoke of a "protective barrier against stimuli", which neurophysiologists today know as the ascending reticular activating system (aras). This is a mechanism by which the central nervous system is protected against stimuli of excessive intensity. Because of this protective mechanism, the survivors of the Andrea Doria, at first, could not be approached or induced to talk. However, in the recovery phase, after the initial shock had worn off, it became possible to question the survivors. It was not even necessary to ask questions, since many of them had a great need to tell their story. They did so, over and over again, to anyone who would listen. They showed pressure of speech and a compulsive need to repeat their story time and again with identical detail and emphasis. This seems to represent a psychological reliving of the trauma in an attempt to master an experience which had proved overwhelming.

The experience of the Andrea Doria episode has called to task the chivalrous principle of "women and children first". It was noted in many instances that this resulted in isolation of children from their parents, with disastrous psychological consequences. This view is supported by the Freud-Burlingham reports on War and Children. During the London bombings in World War II, it was repeatedly observed that children exposed to extremely severe bombing raids showed no particular sign of having been affected if they were in the company of a parent during such an attack. Serious psychological disturbances were largely confined to children who were separated from their parents during such an experience. It was the main conclusion of the Freud-Burlingham report that such disasters have comparatively little significance for children when they threaten their lives or material comforts, but become enormously more important the moment they break up family life and uproot the first emotional attachments of the child within the family group. In another study of the emotional reactions of children to disaster Bloch, Silber and Perry clearly establish a post-disaster increase in dependence needs, characterized by symptoms of regressive behaviour. They observed that a greater need for belonging and reaching out for others were typical disaster responses in children, but that such manifestations could be arrested or even alleviated by the presence of a parent during the disaster situation. These principles found practical application during the Arab-Israeli War of 1948. The Israelis adopted the policy of requiring one parent to remain with the children when the other was sent on a hazardous mission. This, of course, lessened the likelihood of any child becoming doubly orphaned.

(d) *Conclusion.*

It must be remembered that emergencies may not occur until after the danger period is over. When the tension of a military battle is over there is no longer any need to hide one's fears and control one's behaviour as rigidly as before. This is evidenced by the fact that at the end of four years of heavy bombardment, the people of Dover suffered a "collective nervous breakdown."

People react to disaster in many different ways. We cannot predict who will be the coward, who will be the hero and who will have the nervous breakdown. However, among a large group of people, certain reaction patterns are predictable and certain methods of therapy more advisable. The doctor should prepare himself well, for he may suddenly and dramatically be called upon to assume leadership in a disaster-struck area.

Part 2.

INDIVIDUAL EMERGENCIES

I *States of Acute Excitement*

Acutely hostile patients demonstrating anti-social, noisy, overactive, assaultive, violent and destructive behaviour can be found in many psychiatric conditions such as acute mania, catatonic excitement in schizophrenia, epileptic furor and in paranoid patients and the unstable psychopaths.

(a) *Manic States.* These can develop rapidly and change a previously conservative, inhibited person into an irrepressible, demanding, uninhibited, flippant and argumentative character. Such people show marked overactivity, pressure of speech, flight of ideas, and lack a sustained interest in any activity. They are prone to spend money extravagantly, begin ambitious schemes which they never complete, and frequently commit sexual misdemeanours. Open hostility to members of their own family is common. They are often very combative if they are denied any wish or privilege. Even under this constant pressure of activity they often feel little or no need to sleep. Some cannot sleep and cannot eat. These may present as major problems of dehydration and exhaustion. As they become more and more fatigued their excitement increases to even greater manic proportions.

Management.

In the case of the manic patient, prudence requires more control of the patient's activities than is possible at home. The apparently exhaustless energy may suggest that an outlet for it should be provided. An excellent way to placate the patient is to get him to write his memoirs. In doing so he will consume reams of paper and remain less of a nuisance. The hypomanic must be protected from his tendencies to enter into unwise business and financial ventures. Careful supervision of the patient who is not hospitalised is necessary, lest an increase in sex drive lead to irregretable indulgences. The physician must remember to guard against the contradictions and arguments which the manic's irritability, unrestrained speech and activity and his resentment at interference are prone to lead[6]. Sedative baths, wet packs, paraldehyde and chloral hydrate all may have a place in the treatment of such patients, but the best therapeutic measure is to use Chlorpromazine. Occasionally doses as high as 1000 mg. or more are necessary[7]. Some doctors prefer to use ECT to treat the manic patient or a combination of shock therapy and drugs. Of course, psychotherapy is necessary during remissions, which are shown by a gradual slowing and quietening of speech and behaviour.

(b) *Acute Anxiety States and Panic States.*

These are states of fear which are of short duration, lasting hours or days[8]. The inappropriate fear is experienced in attack form, either without an object (free-floating fear) or with an apparent object such as fear of insanity, fear of brain tumor, of cancer etc. It represents little more than an exaggeration of the ordinary energizing emotion of mild fear, so essential to meeting emergencies in everyday life. The characteristic of suddenness of onset, the relative helplessness of the sufferer during the spell, and the tendency of objectless fear to spread, by seizing on various "logical" sources of fear forces the subject to seek help almost desperately. Palpitation, tachycardia, nausea and vomiting, dizziness, fear of fainting and a sense of impending disaster are the typical complaints which bring the patient to the doctor. The emotional basis for an anxiety attack lies in a sudden and overwhelming threat to the individual's reputation, status, economic situation or value system[9]. Often there is a difficulty in developing adult controls of sexual and aggresive drives. The ego may be overwhelmed with id impulses which are unacceptable. Latent homosexual, adulterous, and aggresive desires may be in conflict with the individual's conscience and super-ego and be manifested externally by an acute anxiety attack. This is more likely to occur when the person's inhibitions are subdued as when they are under the influence of alcohol etc. The anxiety state can become chronic and produce an anxiety neurosis or an acute attack can progress to a panic state. In the latter instance the people come to see the doctor because of the intense dread they are experiencing. In the panic state, the patient is victimised by

a wild, unreasoning fear that may drive him into disordered thinking or behaviour. He may reach a point of complete immobilization (eg. during a military battle), or may culminate in frantic overactivity or suicide.

Management.

In some cases it is possible to ease the panic state by airing the emotional problems that precipitated the attack. However, in most cases therapy requires an admission preferably to a general hospital. It is best to induce a state of narcosis using large doses of sedatives, beginning with IM or IV barbiturates. Maintain the narcosis for 24 hours with repeated IM or rectal paraldehyde. The panic state will subside quickly. Further therapy includes encouraging the patient to talk freely about himself and his problems. Frank discussions about painful and frightening issues may be difficult especially if the doctor is a friend or a social contact of the family. In this case it would be wise to refer the patient to another doctor. Airing feelings frequently discharges the anxiety dramatically. Occasionally IV sodium amytal is useful to help the patient vent his views.

(c) *Schizophrenia.* In this condition, catatonic excitement presents with marked hyperactivity, impulsiveness and unpredictable behaviour. Frequently, the schizophrene is destructive and assaultive in reaction to vivid hallucinatory and delusional experiences.

(d) *Paranoid Patients.* These people, too, may suddenly become an emergency by reacting to their delusions and attacking fantasied persecutors or by threatening people with deadly weapons.

(e) *Temporal lobe epileptics.* These people may have psychomotor seizures which take the form of a clouded state characterized by confusion, bewilderment with hallucinations, and outbursts of violence. Frequently there are automatisms in which the patients commits brutal and destructive acts. These furors are characterized by their suddenness, absence of premeditation and by amnesia for them. The extraordinary degree of discrimination and judgment displayed in the psychomotor attack often gives the patient's acts a misleading appearance of deliberation. Usually these seizures last only a few minutes but they may go on for hours or days and grand mal seizures may also be present.

Management.

Mysoline (Primidone) is the best drug to control psychomotor seizures. The dose is 125-150 mg. b-qid. Begin with 125 mg. because of the occasional idiosyncrasy to the drug which is manifested by lethargy, drowsiness and prolonged sleep and by nausea and vomitting. Dilantin and Phenobarb are standard treatment for grand mal seizures. Some doctors prefer the use of Phenurone to control the psychomotor seizure but one must be aware that it may have serious liver and hematopoietic toxicities.

(f) *Delirious Patients.* Briefly, the patient suffering with delirium is characterized by three constant signs and symptoms[10]. These are disorientation for time, place or person; hallucinations, usually visual; and exaggerated emotion, usually great fear, although euphoria and elation may rarely occur, as in Bell's delirium. Delirium can be met with in many psychiatric conditions, especially in the Organic reaction-types or the Toxic-Infective psychoses. Some of the main conditions in which delirium may occur are;

1. *Toxic States*

—Endogenous eg. uraemia, etc.

—Exogenous eg. ethyl alcohol as in Delirium tremens

—Drugs—eg. opium and its derivatives, bromides, barbiturates, thiocyanates, marihuana, cocaine, phenothiazines, sulphas, cortisone, ACTH, belladonna, chloral hydrate or paraldehyde etc.

—Metals — eg. lead etc.

—Gases — eg. carbon monoxide etc.

2. *Febrile States.*

Occurs with pneumonia, malaria, meningitis, encephalitis etc.

3. *Nutritional States.*

Occurs in pellagra, beri-beri etc.

4. *Metabolic States.*

Occurs in thyrotoxicosis, hypoglycemia, porphyria, hypoxia, protein intoxication, sodium deficiency, potassium deficiency, hypocalcemia, water deficiency with hyperosmolarity, water excess with hypo-osmolarity, acute adrenal cortical insufficiency, etc.

5. *Secondary to systemic disease.*

Occurs with cerebral arteriosclerosis, hypertensive encephalopathy, Buerger's disease, pernicious anemia, rheumatic encephalopathy, cerebral trichinosis etc.

6. *Post-Traumatic States* (head injury).

7. *Cardiac Delirium* (heart failure, ventricular fibrillation).
8. *Exhaustion States.*
9. *Post Operative States.*
10. *Burn Psychosis.*
11. *Acute septic delirium.*

Management.

This is primarily the therapy of the infection, toxic state or other disturbing factor that led to the delirium. Every hospital should have at least one room in which an excited, suicidal or delirious patient can be isolated from the remaining hospital population[11]. This room should have protective and suicidal precautions automatically imposed ie, heavily screened windows and a locked door with peepholes. Glass, metal and electrical devices should be avoided. The patient should be deprived of scissors, knives, razors and glass objects. Remove matches and private drugs. Delirious patients should have company at all times, as these patients are very frightened. Keep the lights on at night to prevent shadows which may be misinterpreted as hallucinatory objects. A familiar person, nurse or relative, should be there to help him maintain contact with reality. The sedative of choice is a continuous warm tub bath at a temperature of 95.5-97.5° F. for several hours. Avoid bromides or barbiturates or other drugs such as opiates which may accentuate the delirium. Paraldehyde and chloral hydrate are the best sedatives under these circumstances for only rarely do they accentuate or cause delirium. Paraldehyde should be disguised in fruit juice to hide the unpleasant taste. Newer reports recommend that in most cases of acutely disturbed patients, the injection of an intramuscular Phenothiazine is best [12]. This is better than a barbiturate, which because of its disinhibiting effect may temporarily increase excitement. 50 mg. Largactil (Chlorpromazine) or 5-10 mg. Trilafon (Perphenazine) will quiet these patients and make them more co-operative. This may need to be repeated 3-4 times in 24 hours. Intravenous Sparine (Promazine) 100 mg. is particularly good to inhibit the excitement due to toxic factors, especially drug intoxication and drug withdrawal. These patients should also receive an abundance of nourishment, especially carbohydrates. Their increased cerebral metabolism requires increased amounts of glucose. Saline may be necessary to restore the acid-base equilibrium. Nicotinamide and vitamin preparations may be necessary depending on the individual case. Caffeine may be given as a cardiac stimulant.

These patients should not be shackled or tied down. This just increases their struggle and leads to further exhaustion. However, if attempts to reason with these patients fail, they may have to be restrained against their will. In a very violent case, it is unwise to advance without a force of one man per limb. When this is not feasible, it may be expedient to wet the patient thoroughly first and then entangle him in a wet sheet; this causes a minimum of trauma. If he is fully dressed, slip down his coat so as to restrict his arm movement and undo his braces or belt so his trousers prevent him from kicking. Once he is firmly held an injection can be given. For this he should be held face downwards on a bed or better still on a mattress on the floor so that he cannot fall and hurt himself.

Management of Delirium Tremens.

It has been customary to withdraw alcohol at once but this practice is questionable. Gastric lavage is advisable to remove any remaining alcohol and mucus and other products of a chronic gastritis. Attempts must be made to conserve the strength of the patient suffering from D.T.'s. Place him in bed immediately and keep him under constant supervision with reassurance concerning his fears and hallucinations. Patients may die of exhaustion if struggling under mechanical restraints and the depressing effects of sedatives. Chlorpromazine in divided doses, oral or IM up to 1.0 gm. in 24 hours is effective to prevent overactivity, provide sleep, improve appetite, and relieve anxiety. It is contraindicated when serious infection or cardiac disturbance coexists. Caffeine as a cardiac stimulant is recommended. Corticotrophin in 25 mg. doses q4h helps to bring about a more rapid recovery and improves hypotension[13]. It can be given IM or IV in dextrose and saline solution. Large amounts of glucose are necessary because of the increased cerebral metabolism Vitamins of the C and B complexes are necessary. Alcohol disappears from the blood more rapidly if small doses of insulin are given. NaCl is advisable to combat dehydration and increase the alkali reserve. When delirium and marked tremor co-exist, magnesium may be deficient. With depletion of the serum magnesium (normal is 2.0 mEq./L) give 2 cc. of 5% solution in each buttock. A diet high in calories (3,000-4,000 cals.) and high in vitamins is necessary. If there is no contra-indication such as cardiac failure etc. the patient should be on "force fluids" and should have an intake of about 3-4000 cc. per day. If the patient will not eat, tube feeding may be necessary.

II(a) *Suicidal Risks.*

This may be the most common emergency met with in psychiatric practice. It occurs principally in the depressive states, either manic-depressive psychosis or

the reactive, endogenous and involutional depressions. It is very difficult to assess the validity of a suicide risk, and some believe that it is impossible. However, it is best to be on the alert and recognize the most important premonitory signs[14];

—previous history of suicide in the family

—past history of serious suicide attempts

—persistent ideas of suicide, self-condemnation and especially of guilt

—dreams of death, mutilation, and funerals

—definite plans of how to carry out an attempt

—purchase of any weapon or stockpiling of drugs

—prolonged sleep disturbance

—a view of the future as hopeless and utterly dispairing

People who direct their attention to their surroundings and see the world as full of misery and suffering are less risk than those who direct their attention inwards and are filled with guilt and self-blame. The most frequent time for successful suicide to occur is in the spring and in the autumn, in the mornings, and especially on Sunday mornings. Paradoxically, the patient who was previously apathetic and lethargic, and then becomes active and seems to be getting better is a greater suicide risk than when he was in the depths of his depression. Occasionally suicidal tendencies have a homocidal correlate, so it is advisable to warn the family, for their own safety and especially the safety of the children. It has been shown statistically that the suicide rate is higher in city-dwellers than in the country-folk, and men have a higher suicide rate although women make a greater number of attempts. The rate is also considerably lower in Roman Catholics.

(b) *Other types of Suicidal Tendencies*:

1. *Hysterical personalities.* These people often make dramatic suicidal gestures[15]. They are brought in with superficial cuts on their arms. They may feign unconsciousness with an empty sleeping-pill bottle in view or turn on the gas jet. This type of behaviour is calculated to impress, frighten or force people to yield attention or favours. The only danger is that the patients may accidently go too far and seriously injure themselves. Not all of these cases require hospitalization and the patients respond to firm, direct handling and mild sedation

2. *Immature personalities.* These people have a grossly immature and dependent personality. They may make sudden and impulsive suicidal attempts when faced with a disturbing experience, especially in interpersonal relationships, such as the termination of a love affair. Usually there is wrist-slashing or an overdose of sleeping pills. These attempts are serious because their desire for self-punishment and death are genuine for the moment, but their intensity rapidly fades. In most cases, initial supervision, reassurance and mild sedation is all that is necessary.

3. *Schizophrenics.* There is a real risk of suicide here. Their drive to do this arises from their delusional and hallucinatory experiences. These people should be hospitalised in a mental hospital, sedated and later treated with ECT, insulin therapy or drugs.

Management of the Suicidal Risk:

A correct assessment of the situation is necessary. Some feel the patient should be made to promise the doctor that no attempt will be made and to call him if he feels an impulse coming on. Others feel that this is treating the patient like a child and it leaves the doctor with the responsibility if there is a suicide attempt. Remember patients may be threatening the doctor with suicide as an attempt to manipulate the doctor. Put the onus on the patient; tell him he is an adult and must accept the responsibility for his actions, but nevertheless watch him very carefully.

If a serious threat to life exists, the patient should be brought to the hospital, and close relatives informed. Psychotherapy in which the patient can vent his feelings about his depression and its causes is necessary. Also physical therapies, such as ECT may often be lifesaving as an emergency measure. Usually 4 to 8 treatments of the depressed patient produces a remission in 70-80% of cases. Drug therapy is necessary to relieve agitation and insomnia. Euphoriant drugs are useful for the mild and chronic cases but are not very helpful in the acute cases.

III. *Social Emergencies.*

These are less acute problems, but nevertheless require rather rapid attention.

(1) *Catatonic Stupor.* In this state the person exhibits resistive immobility, mutism, and negativistic refusal of food. Therapy includes ECT, or more recently some ataractic drugs such as Trifluoperazine (Stelazine) and Prochlorperazine (Compazine) have been used to relieve the stupor.

(2) *Fugue and Dissociative States.* Here the individual wanders about staring into space, aimless in his behaviour, with an inability to account for his actions

and identify himself. Therapy here is based on clarifying the underlying factors and usually psychotherapy is satisfactory. Occasionally, fugue states are related to the epilepsies and treatment along this line may be indicated.

(3) *Post Partum Psychosis.* This may occur in the first few weeks after childbirth. It may take the form of delirious, depressive or schizophrenic reaction-types. Generally this condition is more serious if there is no unusual precipitating cause such as the birth of a deformed child. This condition occurs in emotionally immature women or in women with masculine attitudes and strivings. The best therapy is prophylaxis.

(4) *Cerebral Arteriosclerosis.* In this condition there is organic brain dysfunction and this is evidenced by episodes of confusion, excitement and disorientation. There may be impaired intellectual functioning, memory deficits, emotional instability with outbursts of laughter or weeping. Some patients are irritable, aggressive, quarrelsome and paranoid. Noctural attacks of bewilderment may occur. Often the arteriosclerotic patient will become neglectful of his personal hygiene, his clothing and he may fail to bathe. Anxiety and fear reactions with suspicious and delusional trends are common. Suicide is not rare when these patients become depressed. Management is to give them good supervision, correct dietary and hygienic imbalances and mild sedation when they become agitated or excited. There has been a report by Reese and Kant that insomnia, dizziness, headache and delirious confusion can be relieved in these patients by the use of 4 grains of aminophylline q.i.d. Nicotinic acid or its amide is useful to improve the cerebral circulation.

SUMMARY

An attempt has been made to organize and classify the complex topic of psychiatric emergencies. Emergencies have been considered as occurring among large groups of people or specifically to individuals. In many instances the diagnostic features and proper, up-to-date methods of medical management have been presented.

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16. Ibid #6, p. 267.

Abstract

Treacher Collins Syndrome: E.D.T. Ross Anesthesia, *18,* No. 3, July 1963, 350-354.

The syndrome to be described, although rare, is of special interest to the anesthetist because of the marked deformities of mouth and airway. Major features of the syndrome are:

ears — deformity of the pinna often with atresia of the external auditory meatus. Partial or complete deafness may be present.

eyes — oblique palpebral fissure with a droop at the outer canthus. Meibomian glands absent and eyelashes in the medial two-thirds are immature or absent. The eye may lie in an oblique axis.

maxillae — underdeveloped with small antra, infra-orbital ridges are thin and the malar bones rudimentary. Palate is high and foreshortened.

mandible — receding chin and the angle of the jaw is obtuse.

Because of the deformities listed, intubation is difficult or impossible with these patients. The author suggests that inhalation anesthesia coupled with spontaneous respiration is the method of choice with these patients.

Landmarks

One way of dealing with the insane:

In view of the cruelties recently perpetrated in lunatic asylums upon helpless inmates, the recommendation of the late Mr. Charles Burton must to many appear to be a humane one. This gentleman advised that all insane persons "should be comfortably shot"; and with a thoughtful concession to the privileges of the clergy, he added, "I would have it done with the utmost decorum: perhaps by the bishop of the diocese."

Lancet, Jan. 25, 1873.

A pauper at the Woolwich Workhouse suffering from "sunstroke, together with delirium tremens" (we quote from a lay contemporary) had been receiving by the order of the medical officer, a pint of champagne a day. The fact was officially brought before the notice of the guardians at their last meeting and they, after mature deliberation, decided to transfer their interesting but costly protégé to Birkenhead, his native town.

Lancet, March 8, 1873.

Quack Advertisements and Private Houses.

Dr. A. Julius Pollock sends us the following circular found by him in his letter-box and addressed to "The Lady of the House":

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Lancet, March 29, 1873.

Abstracts

The Present Status of Fibrinolytic Therapy: E. E. Clifton. *Angiology, 14,* No. 11, November 1963, 533-541.

Fibrinolysin can be used either locally or systemically to dissolve thrombi. The drugs are, however, expensive and may have undesirable side effects. In early stages when treatment is most efficacious, it is withheld because of expense and possible toxicity. Later when the thrombus is more mature and resistant, treatment is attempted as a last resort, often with poor results. For these and other reasons, the use of fibrinolytic therapy is, as yet, not widely established.

In this article the author discusses various aspects of fibrinolytic therapy including theory, agents, experimental results, indications and contraindications, the various modes of treatment and his clinical experience with this therapy.

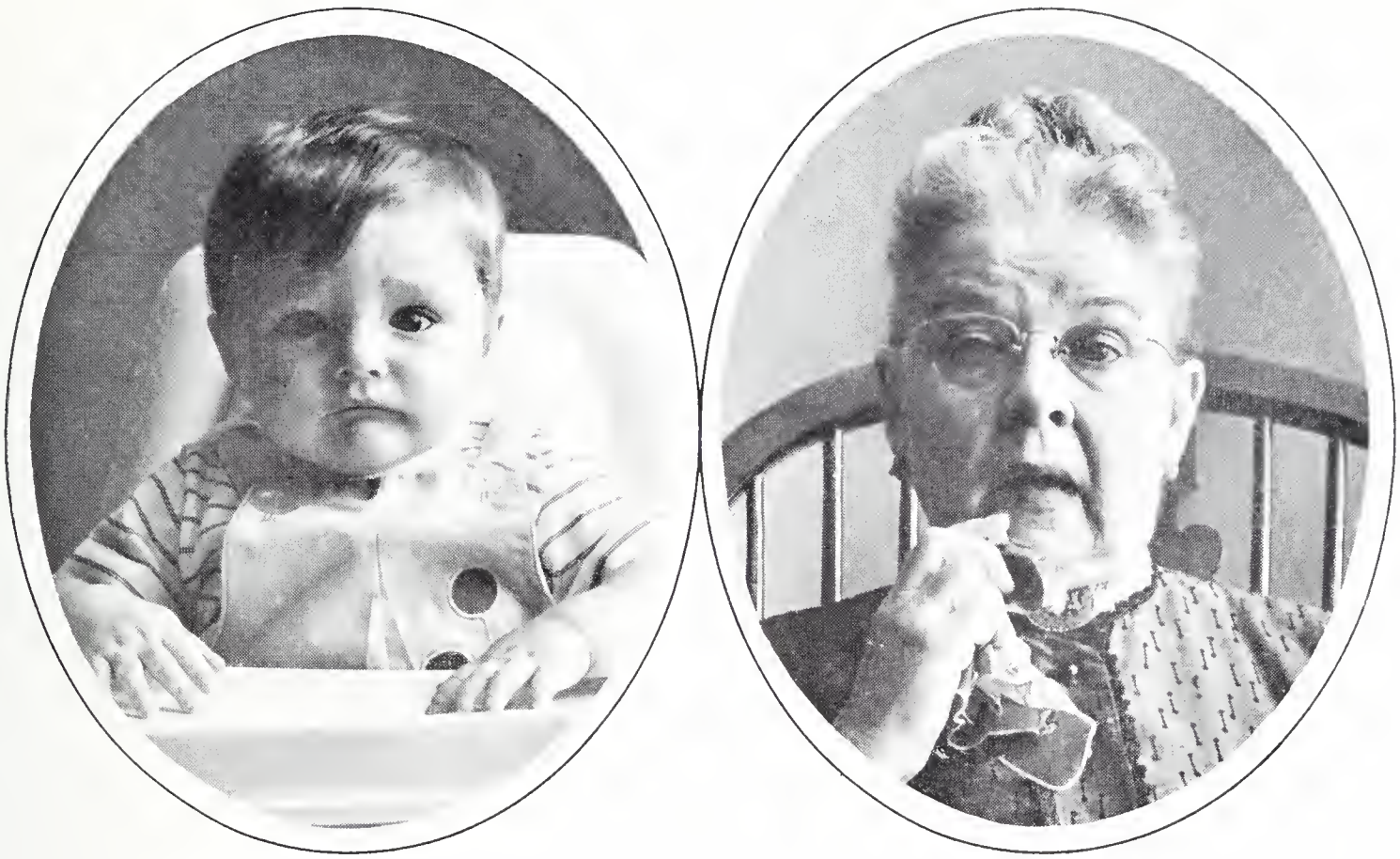
He summarizes by saying that cost rather than side reactions is the major stumbling block to this form of therapy which in his opinion, is very effective in the treatment of venous and peripheral arterial thrombosis and pulmonary embolus.

Ann. Paedriat. 201, 86-94 (1963). *Serum Gamma Globulin Synthesis and the Role of the Bone Marrow Plasmacytes in early Infancy*: O. Lombos, et al.

The increase in serum proteins in cases of plasmacytoma suggested that plasmacytes may produce serum proteins. When investigated in adults, some results suggested that antibodies and gamma globulins are produced by the bone marrow plasmacytes. Other results do not suggest this relationship so the question remains open.

The authors decided to investigate the relationship in infants aged 3-6 mon. They chose infants for the following reasons: no work had been previously carried out on infants; there are few if any bone marrow plasmacytes present at this time; serum gamma globulin is at its lowest in the whole life and finally, in inflammatory diseases infants sometimes react with an increase in gamma globulin level. They hoped to show some correlation between antibody reaction, if any, and plasmacyte number.

From their results the authors state that (a) it is still not known whether plasmacytes produce gamma globulin and (b) a gamma globulin response can occur without any alteration in the bone marrow plasmacytes.



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